County of Los Angeles Department of Mental Health

CULTURAL COMPETENCY ORGANIZATIONAL ASSESSMENT: Follow-Up – 2008

County of Los Angeles
Mental Health System of Care

Prepared by

Terance J. Wolfe, Ph.D.
AE2GIS Group

www.ae2gis.com
terry.wolfe@ae2gis.com

December 2008

Marvin J. Southard, D.S.W., Director, Department of Mental Health

Acknowledgements

This assessment benefited from the assistance of a variety of people, not all of whom can be named individually. At the most fundamental level, employees from the Los Angeles County Department of Mental Health, and its contract service providers shared their thoughtful responses to the *Cultural Competency Organizational Assessment*.

The assessment was undertaken at the request of the Program Support Bureau, Planning Division under the direction of Tara Yaralian, PsyD, and her staff who were instrumental in ensuring that this survey was undertaken and completed in a timely fashion. Dr. Yaralian was responsible for the overall coordination of the study and the distribution of the survey to all potential participants. Without her assistance, this survey would not have been completed.

Acknowledgement goes to the following staff:

Gladys Lee, LCSW
Rebecca Hall, MPhil
Sandra Chang-Ptasinski, Ph.D.
Margaret Lee
Mary Bakchachyan
Edgar Moran
Tammi Robles

Program Support Bureau
Planning Division
of the
County of Los Angeles
Department of Mental Health

December 2008

TABLE OF CONTENTS

LIST OF TABLES

LIST OF CHARTS

EXECUTIVE SUMMARY

PURPOSE OF THE ASSESSMENT

The purpose of this study is to provide a follow-up to a previous assessment of organizational cultural competency within the Los Angeles County Department of Mental Health's System of Care conducted in 2005. The previous assessment was reported in a DMH monograph entitled *Cultural Competency Organizational Assessment* (April 2006). The present assessment reports the findings of the 2008 survey, and compares them with the 2005 survey results.

The goal of the assessment is not to evaluate or judge, but rather to consider the current state. It provides two snapshots in time of the cultural competency of the organizational infrastructure of the Los Angeles County System of Mental Health Care. As such, it provides insight into developmental opportunities for enhancing the cultural competency of the overall system of mental health care and points to opportunities for further research.

ORIENTATION OF THE ASSESSMENT

This assessment is unique in that its focus is on the cultural competency of the overall organizational system of care as opposed to the cultural competency of individual service providers.

The Cultural and Linguistic Workgroup (CLW), the predecessor of the current Cultural Competency Sub-Committee, identified five focus areas for its strategic plan (County of Los Angeles Department of Mental Health, 2002). These are (1) structure, (2) policy, (3) funding, (4) human resources, and (5) culturally competent system of care, treatment outcome measurement, and training. These five focus areas provided the initial framework for the design and implementation of the original assessment. An additional focus area was added based upon the values and principles embedded in the Mental Health Services Act (MHSA).

As an *organizational* assessment, survey questions were addressed to service providers within the Los Angeles County DMH System of Care. Over 3,400 responses were received from DMH and contract agency employees for the 2008 survey. Survey responses provided follow-up insight into the *organizational* cultural competency of the System of Care.

FINDINGS

Survey findings were categorized based upon favorable versus unfavorable responses, and summarized in a performance "scorecard" (Table 17). Overall, the percentage of unfavorable responses is not high. However, the results are influenced by the high percentage of neutral responses. This suggests a lack of respondent knowledge or information about specific issues assessed through this survey. This has implications for developing and using more effective

communication processes and/or facilitating a broader base of engagement and involvement among system service providers.

Overall, the performance scorecard indicates that the percent favorable responses by question exceed the seventy percent cut-off for twenty-eight of forty-two (61%) questions. The percent favorable responses by question for eighteen questions (39%) fall below the seventy percent cut-off score. This compares very favorably with the previous assessment and is the inverse of the 2005 results.

As with 2005, the largest percentages of favorable responses by question are in the focus areas "Policy" (86%) and "MHSA" (100%). Alternatively, the percent favorable responses by question for each of the other six assessment focus areas are less than seventy (70) percent – the selected cut-off score. These six focus areas and their percent favorable responses by question include the following:

- Cultural competency system of care (67%: 6 of 9 questions)
- Treatment outcome measurement (60%: 3 of 5 questions)
- Human Resources (57%: 4 of 7 questions)
- Training (50%: 2 of 4 questions)
- Structure (43%: 3 of 7 questions)
- Funding (0%: 0 of 3 questions)

There is a marked upward shift in respondent perceptions of the system's performance on virtually every measure. A comparison of the 2005 with the 2008 results in Table 17 (pages 15 – 16) reveals a positive upward improvement in assessment on average of nine points across all forty-six questions.

There is a measurable improvement in the average percent favorableness across thirty-nine (85%) questions between 2005 and 2008 (Chart 1, page 16). Based upon this as an aggregate measure, four of eight focus areas exceed the seventy percent cut-off (policy, system of care, treatment outcome measurement, MHSA), and four fall below it (structure, funding, HR, training).

There is a demonstrable improvement in the number of questions that exceed the seventy percent cut-off between 2005 and 2008 for six of the eight focus areas (Chart 3, page 19). These range from a thirty-three (33) percent increase for MHSA to a three hundred (300) percent increase for human resources.

By far, the three areas of assessment that warrant further review and action are funding (0% favorable), structure (43% favorable), and training (50% favorable). Human resources (57% favorable) is the fourth area that warrants attention. There is also room for improvement in cultural competency system of care and treatment outcome measurement. See Tables 19 – 27.

RECOMMENDATIONS

A variety of recommendations are offered for addressing the issues identified through the comparison of survey findings between 2005 and 2008. They include suggestions for further research in the form of targeted interviews and focus groups to better understand various findings. They also include the following: eliciting more active community involvement, making funding for culturally-specific services and support more visible to service providers and community members, addressing human resource issues related to cultural competence, making the system more accessible to diverse communities, developing better and more culturally sensitive outcome measures, and providing more support for cultural competency to enhance on-the-job impact.

The following specific recommendations are provided based upon analysis of the survey data:

Structure

- Provide mechanisms to support community involvement and participation through facilitating access, engaging the community through consultation on policies, procedures and practices, and including the community in local (Service Area) decision-making, as appropriate.

Policy

- Develop, communicate and utilize a culturally appropriate complaint resolution process.

Funding

- Make funding decisions transparent.
- Use funding to train, support and reward employees for culturally competent skills.
- Encourage funding to support new initiatives that support and enhance cultural and linguistic competence.

Human Resources

- Develop a Human Resources strategic plan for staff development. This plan should address the following issues:
  - Develop and implement career paths for ethnically-diverse employees.
  - Hire/train for skills that meet the cultural and linguistic needs of the target population.
  - Train managers for sensitivity to cultural differences in performance evaluation.
  - Evaluate performance in relation to cultural – not just linguistic – competency.

Culturally Competent System of Care

- Focus on the development and implementation of culturally appropriate service delivery models.
- Encourage inter-agency collaboration in the development and delivery of innovative and culturally responsive services.
- Gather, communicate and utilize targeted consumer group demographics.
- Encourage program evaluations to identify and address service gaps, barriers or inappropriate services.

Treatment Outcome Measurement

- Review programs on a periodic basis for consistency with policies and procedures.
- Evaluate programs for cultural sensitivity and effectiveness in meeting the needs of culturally and linguistically specific populations.

Training

- Increase internally and externally provided training opportunities available to staff.
- Overcome impediments to training through time-off, travel assistance, conference payments, and balancing productivity pressures with professional development opportunities.
- Identify culturally specific opportunities for supporting ethno-cultural staff and volunteers.
- Encourage managers and supervisors to support staff time for cultural competency training.
- Move diversity training beyond "awareness" to purposeful and practical skill development.

NEXT STEPS

While many actions have been undertaken over time, they have not been driven by the survey findings. There is an invitation for DMH and the Mental Health System of Care to utilize these findings to produce data-driven organizational change and improvement. Several next steps can be suggested based upon the present survey findings. They include both inquiry and action.

Inquiry

1. Conduct a focus group and interview study for following up on and digging beneath the 2008 survey findings as outlined above. The survey findings are used to drive the next phase of research. Are the issues surfaced through the survey real, misperceptions, a function of communication problems, etc? Interviews and focus groups can be used to tease out and clarify the issues, and to identify clear arenas for action.
2. Use the interview and focus group study to probe into and develop a deeper understanding of what "neutral" responses mean. What accounts for the high percentage of neutral responses?

Action

1. Devise specific plans of action in relation to the recommendations identified above. Formulate a strategic action plan for developing and enhancing system-wide organizational cultural competency. Such a plan would address all CLW focus areas and MHSA as measured in this survey. The plan should include measurable goals, resources, accountability, and timelines for each of the survey areas.
2. Develop a consumer and family member survey to assess organizational cultural competence from the user's point-of-view.

CONCLUSION

This is not an evaluative study. The purpose of this Re-Assessment is to provide a current measure of the system of care in the context of the CLW focus areas and relevant portions of the MHSA. This provides an index of the organizational cultural competency of the system. This investigation accomplished that purpose. From the analysis performed in this study, Table 17 is a performance scorecard that provides the best summary of the Los Angeles County Department of Mental Health System of Care's current state of organizational cultural competency.

Department of Mental Health
Los Angeles County

Los Angeles County Mental Health System of Care
Cultural Competency Organizational Assessment

Submitted by

Terance J. Wolfe, Ph.D.
AE2GIS Group

www.ae2gis.com
terry.wolfe@ae2gis.com

December 2008

INTRODUCTION

PURPOSE OF THE ASSESSMENT

The purpose of this assessment is to provide a three-year follow-up analysis to earlier surveys of Organizational Cultural Competency conducted within the Los Angeles County Mental Health System of Care in 2002 and again in 2005. The earlier surveys sought to establish baseline assessments of organizational cultural competency within the System of Care.

As with the earlier studies, the goal of this assessment is not to evaluate or judge, but rather to assess the current state – to take a snapshot in time. This assessment provides ongoing insight into developmental opportunities for enhancing the overall cultural competency of the comprehensive system of mental health care in Los Angeles County.

BACKGROUND OF THE ASSESSMENT

This survey is a follow-up study of earlier Organizational Cultural Competency Assessments conducted within the Mental Health System of Care in 2002 and again in 2005. The Department of Mental Health (DMH) sought to implement a Cultural Competency Organizational Assessment to consider the capability of the System of Care, including staff and service providers, to address the cultural and linguistic requirements of its large and varied client communities. The findings of the earlier assessments are published in DMH monographs entitled, *Cultural Competency Organizational Assessment*, December 2003 and April 2006.

There is a wealth of literature on the issues and the challenges inherent in individual cultural competency, as well as practice recommendations for its development (see, for example, Lecca, 1998; Sue, et al, 1998; Rundle, et al, 2002; Cox, 2003; Peterson, 2004; Anand, 2006; Gupta, 2007; Tseng & Streltzer, 2008). In contrast, there is a dearth of literature on organizational cultural competency. In this sense, the Los Angeles County Department of Mental Health is breaking new ground. For the purposes of this assessment, organizational cultural competency is defined as:

> *Organizational policies, practices and procedures causally related to the effective provision of culturally and linguistically appropriate services, where "culture" is broadly defined*

DMH's initiatives in organizational cultural competency represent a pioneering effort in the development and refinement of a new concept and approach to intervention. As a result, the 2002 study had to be built from the ground up. This included a review of the literature as well as the use of multiple forms of original data collection including interviews, focus groups, a survey, and review of DMH and System of Care archival information such as policies, informational and promotional materials, etc. These were materials that were available in offices and clinics throughout the system.

Literature Review. Aside from noting the dearth (virtually absence) of any published literature on organizational cultural competency, the significant finding of the literature review was the discovery of an initiative in the Ministry of Children and Families, Vancouver, British Columbia. The Ministry developed an initial template for structuring an organizational cultural competency assessment. This was used as a conceptual point of departure for developing the DMH survey.

Interviews. Sixteen people were interviewed as part of the 2002 assessment including DMH Staff and Contractors, family and community members, and consumers.

Focus Groups. Eight focus groups were conducted representing a broad cross-section of the system including:

- Cultural and Linguistic Workgroup (Inter-agency, consumers, family). This was the predecessor of the current Cultural Competency Subcommittee.
- Older Adults Task Force (Inter-agency)
- Westside Coalition (SAAC; inter-agency, consumers, family members)
- SAAC 7 (Inter-agency, consumers, family members)
- Joint District Chiefs Meeting (DMH Staff)
- Coastal Asian-Pacific Clinical Staff (DMH Staff)
- Latino Mental Health Coalition (Consumers, family members)
- African Community Resource Center (Consumers, family members).

Survey. Findings from the literature review, the interviews and the focus groups were used as the key informational inputs into the development of a custom designed survey for DMH. As mentioned, the assessment tool developed by the Ministry of Family and Children, Vancouver, British Columbia, Canada[1] served as a key point of departure. Their tool was significantly modified to reflect the five categories of the Strategic Plan formulated by the Cultural and Linguistic Workgroup (CLW), the predecessor of the current Cultural Competency Subcommittee.

Through its strategic planning initiatives, the CLW identified five categories for development. The five categories are: (1) Structure, (2) Policy, (3) Funding, (4) Human Resources, and (5) Cultural Competency System of Care, Treatment Outcome Measurement and Training. For the survey cultural competency system of care, treatment outcome measurement and training were broken out into separate survey categories. This resulted in seven categories of assessment. For the 2005 Re-Assessment, an eighth category (and four new questions) was added to include key concepts promoted by the Mental Health Services Act. A copy of the final survey is included in Appendix 1.

The Organizational Cultural Competency Assessment has benefited from the joint support and participation of DMH and the Association of Community Human Service Agencies (ACHSA). For each assessment, the survey was administered only to service providers (DMH and contractor). Both agencies have actively encouraged their employees to participate in each administration of the survey. The nature of the survey questions precluded responses from consumers and community members.

For each administration of the survey, respondents were provided the opportunity of completing the survey on-line or returning a hard copy. Anonymity and confidentiality were assured through the use of a third-party consultant, as well as a "fourth-party" web-hosting service in the Eastern United States. All data are reported in the aggregate with no meaningful way of identifying any individual respondent.

[1] Government of British Columbia, Ministry of Children and Families, Cultural Competency Assessment Tool, 2001

DMH has undertaken many actions in relation to cultural competency since the original administration of the survey in 2002. Some of these have been driven by the enactment of MHSA. A few were influenced by the 2002 survey findings and recommendations (*Cultural Competency Organizational Assessment,* December 2003). Many of these actions are documented in the Training and Cultural Competency Bureau report entitled *Cultural Competency Organizational Assessment Progress Report* (December 2005).

A number of additional initiatives help to account for observed changes in organizational cultural competency assessments between 2005 and 2008. These include (1) outreach to under-represented ethnic populations (UREP), (2) enhancing Department-level awareness of cultural competency through ongoing MHSA implementation meetings, (3) developing strategies for increasing full-service partnership (FSP) authorizations for UREP's, (4) participation in the State Cultural Competency Advisory Committee, (5) establishing specific Cultural Competency Work Plan goals, and (6) collaboration with the California Institute of Mental Health to examine the cultural relevance of three core MHSA concepts: wellness, resilience and recovery.

The present study reports on the 2008 findings in relation to those of 2005. It is not possible to ascertain if any noted improvements in the favorableness of the survey responses are directly related to specific initiatives undertaken as a result of the 2005 findings.

QUANTITATIVE DATA COLLECTION - 2008

The re-assessment survey was administered between September and November 2008. The survey employed a census sampling procedure in which surveys were distributed to the staff of every service provider within the Los Angeles County Department of Mental Health's System of Care. Approximately 10,000 surveys were distributed. 3,663 surveys were returned of which 220 were duplicates, incomplete or otherwise unable to be meaningfully analyzed. They were dropped from the data set. This resulted in 3,443 usable surveys, and an estimated thirty-four (34) percent response rate. This value is considered extremely acceptable for large sample surveys of this sort.

QUANTITATIVE FINDINGS

The findings are presented primarily as a comparison between the 2008 and the 2005 survey results. Some supplementary analysis of the 2008 findings is provided in order to provide a deeper look at focus area findings based upon selected demographic variables. As mentioned the 2008 findings are based upon 3,443 usable responses, whereas the 2005 findings are based upon 1,919 usable responses. The 2008 findings represent a seventy-nine (79) percent increase in the response rate over 2005.

DEMOGRAPHICS

There were 3,443 respondents to the 2008 survey. Respondents were asked a variety of demographic questions. The demographic distribution of the 2008 respondents in relation to the 1,919 respondents in 2005 based upon self-reports is as follows:

Current Position Level. Table 1 shows the distribution of respondents by level within their employing organization. The 2008 distribution by position as a percent of total responses parallels that of 2005. The majority of respondents (40%) held clinical positions. There was a slight decrease in clinical responses as a percent of total, and a slight increase in support staff responses as a percent of total. Five percent (n = 169) of the 2008 respondents did not identify their position.

Table 1: Distribution of Respondents by Position

	Executive	Managerial	Supervisory	Clinical	Support	Other	NR	Total
2008	94	462	351	1382	825	160	169	3443
	3%	13%	10%	40%	24%	5%	5%	
2005	52	259	190	808	388	222		1919
	3%	13%	10%	42%	20%	12%		

Current Organization: DMH. Table 2 shows the distribution of survey respondents who identified themselves as DMH employees by work location. The majority of DMH respondents identified themselves as Program (37%) or clinic (32%) based. This data is not available for the 2005 survey.

Table 2: Distribution of DMH Respondents by Work Location

	Admin/HQ	Program	Hospital	Clinic	Other	NR	Total
2008 *	356	657	154	565	35		1767
% of DMH	20%	37%	9%	32%	2%		
% of total	10%	19%	5%	16%	1%	49%	3443

* 2005 data for this variable not available

The proportion of respondents from DMH versus contractors was very balanced. Fifty-one (51) percent, or 1767 respondents, self-identified as DMH employees; forty-nine percent of respondents were contractors.

Current Organization: Contractors. 1,676 of the respondents (49%) self-identified as contractors. They represented 255 different contract agencies. The range of responses per agency ranged from 1 to 159. Nineteen agencies had twenty (20) or more respondents. These nineteen agencies accounted for fifty-seven (57) percent of all the contract agency responses. The list of contract agencies identified, and the number of

survey responses from each, is included as Appendix 2. Table 3 shows the nineteen contractors with the highest survey response rates.

Table 3: Contractors with the Highest Survey Response Rate

Contractor	Responses
Pacific Clinics	159
Foothill Family Service	112
San Fernando Valley Community Mental Health Center, Inc.	80
Vista Del Mar	80
Penny Lane	71
Didi Hirsch	53
Star View	43
St John's Child and Family Development Center	41
ALMA	38
Child and Family Guidance Center	37
The Guidance Center	35
Child & Family Center	30
South Central Health and Rehabilitation Program (SCHARP)	30
Exodus Recovery	28
Gateways	28
Special Services for Groups	26
The Learning Clinic	26
BRIDGES	20
Personal Involvement Center	20

Populations served. Table 4 shows the distribution of respondents by primary population served by their organizations. Respondents were invited to check all that apply. As can be seen, an organization may have served more than one population, for example, adults and older adults. The largest percentage of populations served included children (57%), adults (48%), TAY (22%), and older adults (21%). As can be seen, there were significant increases across the board between 2005 and 2008 in each of the populations served. TAY was not a response category in the 2005 survey.

Table 4: Distribution of Respondents by Population Served

	Older Adult	Adult	TAY	Children	Pub Grdn	Cal WORKS	Jail	Hospital	Crisis	Other	NR	Total[2]
2008	729	1635	748	1946	163	557	197	160	574	322	201	7232
	21%	48%	22%	57%	5%	16%	6%	5%	17%	9%	6%	
2005	304	866		1071	61	360	85	49	264	252		3312
	9%	26%		32%	2%	11%	3%	1%	8%	8%		

Service Area. Table 5 shows the distribution of respondents by Service Area. There was a significant decrease in the percent of respondents identifying Service Areas 2 and 3 relative to the 2005 results. The findings may reflect a significant shift in service area coverage to countywide responsibilities since the 2005 survey. Alternatively, respondents may not be aware of their Service Area designations. Unfortunately, this cannot be ascertained from the present study since "Countywide" was inadvertently overlooked as a response category in the design of the 2008 survey.

Table 5: Distribution of Respondents by Service Area

	SA1	SA2	SA3	SA4	SA5	SA6	SA7	SA8	Countywide	NR	Total
2008	141	297	425	316	237	215	256	250		1306	3443
	4%	9%	12%	9%	7%	6%	7%	7%		38%	
2005	91	281	514	175	136	99	211	138	274		1919
	5%	15%	27%	9%	7%	5%	11%	7%	14%		

Gender of Respondent. Table 6 shows the distribution of respondents by gender. Nearly seventy (70) percent of respondents self-identified as female. "Transgender" was included as a response category for the 2008 survey. While the percent of respondents who self-identified as either male or female decreased relative to the 2005 findings, there was a 5% increase in those who chose not to identify their gender.

Table 6: Distribution of Respondents by Gender

	Male	Female	Transgender	NR	Total
2008	796	2383	38	226	3443
	23%	69%	1%	7%	
2005	500	1374		45	1919
	26%	72%		2%	

[2] Respondents were able to check all that applied thereby producing a number in excess of actual number of respondents.

Time in Position. Table 7 shows the distribution of respondents by length of time in current position. For 2008, 78% of all respondents had been in their current position for less than five years; 92% had been in their position for less than ten years. This pattern is virtually identical to 2005. Of note, however, is the significant increase in those who had been in their position between 1 – 3 years, and the significant decrease of those who had been in their position between 4 – 5 years.

Table 7: Distribution of Respondents by Time in Current Position

	< 1 yr	1-3yrs	4-5 yrs	6-10 yrs	11-15 yrs	16-20 yrs	>20 yrs	NR	Total
2008	926	1325	395	469	135	65	80	48	3443
	27%	39%	12%	14%	4%	2%	2%	1%	
2005	547	498	399	302	79	41	34	19	1919
	29%	26%	21%	16%	4%	2%	2%	1%	

Time with Organization. Table 8 shows the distribution of respondents by length of time with current organization. 63% indicated they had been with their present employer for less than 5 years. 81% had been with their employer for less than 10 years. This pattern is similar to, but slightly greater than, the 2005 findings. Similar to the pattern in the previous question for time in current position, there was a significant increase in those with their organization from 1 – 3 years, and a significant decrease in those with their organization from 4 – 5 years.

Table 8: Distribution of Respondents by Time with Current Organization

	< 1 yr	1-3yrs	4-5 yrs	6-10 yrs	11-15 yrs	16-20 yrs	>20 yrs	NR	Total
2008	672	1075	415	618	227	116	151	169	3443
	20%	31%	12%	18%	7%	3%	4%	5%	
2005	356	379	358	365	146	80	100	135	1919
	19%	20%	19%	19%	8%	4%	5%	7%	

Time in US – Non US-born. Table 9 shows the distribution of respondents by length of time in US for non-US born employees. Of the 3443 respondents, 784 (22%) self-identified as non-US born. For those who self-identified as non-US born, 59% have lived in the US for over 20 years. 90% have been in the US for over 10 years. 96% have been in the US for over 5 years. The overall pattern of 2008 results is similar to that of 2005.

Table 9: Distribution of Respondents by Time in US (non-US born)

	< 1 yr	1 – 3 yrs	4 – 5 yrs	6–10 yrs	11-15 yrs	16-20 yrs	> 20 yrs	NR	Total[3]
2008	2	11	20	56	84	146	465		784
	.3%	1%	3%	7%	11%	19%	59%		100%
	2	11	20	56	84	146	465	2659	3443
	.1%	.3%	.6%	2%	2%	4%	14%	77%	
2005	10	7	13	27	52	72	327		508
	2%	1.4%	2.6%	5.3%	10%	14%	64%		100%
	10	7	13	27	52	72	327	1411	1919
	1%	0%	1%	1%	3%	4%	17%	74%	

Age of Respondent. Table 10 shows the distribution of respondents by age. 63% of all respondents were between the ages of 26 – 55 years of age. This is a significant decrease from the 2005 findings where 76% of all respondents fell within this range.

Table 10: Distribution of Respondents by Age

	18-25 yrs	26-35 yrs	36-45 yrs	46-55 yrs	56-65 yrs	Over 65	NR	Total
2008	152	877	708	559	410	76	661	3443
	4%	26%	21%	16%	12%	2%	19%	
2005	129	572	465	428	263	35	27	1919
	7%	30%	24%	22%	14%	2%	1%	

Education. Table 11 shows the distribution of respondents by level of education. There are significant differences between self-reported educational attainment between 2005 and 2008. While there was a slight decline in those who self-reported either "high school" or "some graduate school", there was a significant decline in those who reported either "some college" or "Masters degree". At the same time, there was a significant increase in those who self-reported a "4 year degree". Whereas the highest incidence of attained education in the 2005 study was at the Master's degree level (34%), the highest incidence in the 2008 study is 4-year degree (44%). Fully 94% of the 2008 respondents indicated some degree of college education. There was a significant decline in those who self-reported an advanced degree (MS, PhD/PsyD, MD) between 2005 (47%) and 2008 (38%).

[3] Only that portion of the respondents who were non-US born responded to this question. We are unable to determine how many non-US born respondents chose not to respond to the question.

Table 11: Distribution of Respondents by Level of Education

	Hi School	Some College	4 Yr Degree	Grad School	MS	PhD	MD	Other	NR	Total
2008	61	283	1526	146	576	574	132	21	124	3443
	2%	8%	44%	4%	17%	17%	4%	.6%	4%	
2005	80	362	325	145	646	219	46	96		1919
	4%	19%	16%	7%	34%	11%	2%	5%		

Dominant Racial Identity. Table 12 shows the distribution of respondents by dominant racial identity. Public agencies tend to report "race" using five different categories: Asian/Pacific Islander, Black, Hispanic, Native American/Alaska Native, and White. These are the categories most frequently employed on job applications, and historically the primary basis for nationwide statistical comparisons of race. While this is recognized as controversial within the community of those who specialize in and/or advocate for diversity issues, nonetheless, it was deemed important as a baseline measure of racial distribution within the system. The purpose of this question was to provide a measure of racial distribution based upon these commonly used categories.

Approximate estimates for Los Angeles County are provided from the 2000 US Census. Based on this comparison, service providers who self-identified as Hispanic represent a significantly smaller percent of the survey sample than is representative of the Los Angeles County Hispanic population. Alternatively, survey respondents who identified as white represent a significantly larger percent of the survey sample than is representative of Los Angeles County. One must use caution in drawing conclusions about, for example, hiring practices as there is a self-selection factor operating in the response rates. This data is not available from the 2005 survey.

Table 12: Distribution of Respondents by Dominant Racial Identity – 2008.

	A/PI	Black	Hispanic	NA/AN	White	NR	Total
Survey	419	495	930	24	1313	262	3443
	12%	14%	27%	1%	38%	8%	
Census	13%	10%	47%	1%	29%		

Racial-Ethnic Identity. Table 13 shows the distribution of respondents by self-reported racial and ethnic identity. This question provided respondents with maximum flexibility to self identify their racial and ethnic identity as was done in the 2000 US Census. It is a counterbalance to the previous question that required respondents to identify themselves according to a delimited – and politicized – set of identity group categories. The total number of responses exceeds the total number of respondents; some chose to check more than one category. The pattern between 2005 and 2008 is quite similar. There is a 4% increase in self-reported ethnic identity for both whites and blacks.

The list of racial-ethnic identities was the subject of much discussion within the Cultural and Linguistic Workgroup prior to the 2002 survey. This issue strikes a chord for all who participate in the system of care. Resources are often attached to a demonstrated need, where a need is often defined in terms of disparities in resource allocations based upon racial-ethnic identity. Some identity groups clearly perceive themselves as "invisible minorities". A consequence of "invisibility" is a lack of funding. This speaks to the recognition by DMH for addressing under-represented ethnic populations (UREP).

Table 13: Distribution of Respondents by Self-Reported Racial/Ethnic Identity

	2005		**2008**	
Racial/Cultural Ethnic Identity	Frequency	Percent	Frequency	Percent
White	749	35%	1358	39%
Black	260	12%	535	16%
Hispanic	559	26%	963	28%
American Indian/Alaska Native	57	2.7%	95	3%
Chinese	81	3.8%	155	5%
Japanese	22	1%	52	2%
Filipino	67	3.2%	153	4%
Other Asian/Pacific	15	.7%	34	1%
Other Non-White	9	.4%	19	1%
Korean	34	1.6%	45	1%
Indochinese	3	.1%	3	.1%
Amerasian	4	.2%	1	0
Cambodian	5	.2%	12	.3%
Samoan	0	0%	9	.3%
Asian Indian	26	1.2%	33	1%
Hawaiian Native	2	.09%	4	.1%
Guamanian	1	.05%	0	0
Laotian	2	.09%	3	.1%
Vietnamese	22	.1%	31	1%
Other Black	8	.4%	15	.4%
Other White	46	2%	110	3%
Other Hispanic	40	1.9%	46	1%
Other Native American	5	.2%	22	1%
Other	75	3.5%	244	7%
Unknown/Not Reported	26	1.2%	10	.3%
Total	2118[4]		3952	

[4] Some respondents checked more than one racial and cultural/ethnic identity.

Racial/Ethnic Identity – Other. "Other" was a response option to the question regarding racial and ethnic identity. 241 respondents (7%) selected other. They identified ninety-five (95) other racial/ethnic identifications. The list of other racial/ethnic identities is included in Appendix 3. Of the 95, Table 14 displays the most frequently occurring.

Table 14: Most Frequently Occurring "Other" Racial/Ethnic Identities.

"Other" Race	Frequency
Armenian	28
Mexican-American	18
Mexican	16
Jewish	11
Middle Eastern	10

Languages Spoken. Table 15 shows the distribution of respondents by self-reported languages spoken. Twelve non-English threshold languages were listed in the survey. Arabic was not a response option in 2005. Two changes between 2005 and 2008 are the significant increase in Spanish language competency (from 37% to 56%), and the significant decrease in "other" (from 39% to 18%). Nonetheless, these 18% may be suggestive of "invisibility" and unmet linguistic and/or cultural needs in the system.

Table 15: Distribution of Respondents by Self-Reported Languages Spoken

	2005		**2008**	
Language	Frequency	Percent	Frequency	Percent
Arabic			27	1%
Armenian	82	4.5%	66	3%
Cambodian	9	.5%	8	.4%
Cantonese	46	2.5%	64	3%
Chinese	45	2.5%	75	4%
Farsi	28	1.6%	47	2%
Korean	40	2.2%	40	2%
Mandarin	47	2.6%	66	3%
Russian	31	1.7%	33	2%
Spanish	660	37%	1174	56%
Tagalog	62	3.5%	108	5%
Vietnamese	37	2.1%	33	2%
Other	702	39%	374	18%
Total	1,789		3612	

Country of Origin. 805 respondents (23%) identified as coming from different countries. They represented 92 different countries. The responses per country identified ranged from 1 to 199. Sixteen countries had ten (10) or more respondents. These sixteen countries accounted for seventy-four (74) percent of the respondents from all non-US countries. The list of countries identified, and the number of individuals from each, is included as Appendix 4. Table 16 shows the sixteen countries with the highest survey response rates.

Table 16: Most Frequently Identified Countries of Origin (non-US).

Country	Frequency	% of Total (non-US)
Mexico	199	25%
Philippines	87	11%
El Salvador	43	5%
Iran	32	4%
Vietnam	32	4%
Korea	25	3%
China	24	3%
Armenia	22	3%
Canada	21	3%
Guatemala	21	3%
Hong Kong	21	3%
India	17	2%
Taiwan	16	2%
Brazil	12	1%
Japan	11	1%
Russia	10	1%

SURVEY RESULTS

A Likert-style survey was employed for measuring respondent attitudes about the seven strategic focus areas of the system of care, as well as questions on the Mental Health Services Act. The survey employed a 5-point scale from strongly disagree (1) to strongly agree (5).

Favorable scores were defined as responses coded as strongly agree (5) or agree (4). Neutral scores were defined as responses coded as neither agree nor disagree (3) or no response. Unfavorable scores were defined as responses coded as disagree (2) or strongly disagree (1).

The overall pattern of the distribution of responses is summarized in Table 17 for both 2005 and 2008. The percent favorable responses are indicated for each of the seven CLW focus areas and issues related to key concepts in the Mental Health Services Act. Table 17 also provides the overall percent favorable responses for the entire survey.

In our society, seventy percent is regarded as satisfactory performance. A seventy (70) percent favorable response, then, becomes a conservative measure of the System of Care's organizational cultural and linguistic health and vitality. Therefore, for each of the eight focus areas, all questions with percent "favorable" responses below 70% are regarded as areas for possible improvement. The reader of this report may choose a more stringent standard, such as 75% or 80%, or a more lenient standard, such as 60% or 65%. This choice has implications for decisions, resource allocations and actions.

Table 17 can be functionally regarded as a "scorecard" of organizational cultural competency performance for the Los Angeles County Mental Health System of Care. It provides snapshots at two moments in time. It allows us to observe changes – in this case, improvements – on a set of measures of organizational cultural competency.

Table 17 provides two key performance metrics. Metric 1 is based upon the percent favorable (unfavorable) responses for each question within each focus area. Metric 2 is based upon the average percent favorable responses across all questions within each focus area. Metric 1 is a stricter performance metric. It provides more guidance for diagnosing and assessing specific performance improvement opportunities.

Metric 1 identifies the total number of questions within each Focus Area that have percent favorable responses greater than or equal to seventy (70) percent. This metric looks at *the percent favorable (unfavorable) responses for <u>each</u> question <u>within</u> each focus area*. Table 17 indicates exactly which questions within each Focus Area score above the cut-off and which score below. For example, for the Focus Area "structure", three of seven questions (43%) have percent favorable scores greater than 70%. They are Q17, Q18 and Q21.

Metric 2 provides *the average of the percent favorable responses <u>across all</u> questions <u>within</u> each Focus Area*. This reflects the average percent favorableness across all questions and all respondents for each Focus Area. For example, for the Focus Area "structure", the average percent favorable responses across all of the questions is sixty-six (66) percent.

Findings Spotlight: Areas of Concern

Metric 1. Six of eight Focus Areas (75%) warrant concern based upon the number of questions that fall below the 70% cut-off: Funding (100%), Structure (57%), Training (50%), Human Resources (43%), Treatment Outcome Measurement (40%), and System of Care (33%).

Metric 2. Four of eight Focus Areas (50%) warrant concern: Funding (54%), Training (65%), Structure (66%), and HR (69%).

Table 17: Distribution of Percent "Favorable" Responses by Question and by Focus Area – Cut-off Score = 70%, 2008, n = 3,443

# of Survey Questions	% Favorable Responses[5]	Structure	Policy	Funding	Human Resources	System of Care	Treatment Outcomes	Training	MHSA
0	90 – 99								
15	80 – 89	Q17, Q21	Q24, Q26 Q27,Q28 Q30			Q42, Q43 Q45	Q54		Q59, Q60 Q61, Q62
13	70 – 79	Q18	Q25		Q34, Q35 Q37, Q38	Q41, Q44 Q46	Q50, Q51	Q55, Q56	
11	60 – 69	Q19, Q22	Q29	Q32	Q36, Q39	Q47, Q48 Q49	Q52, Q53		
4	50 – 59	Q20		Q31				Q57, Q58	
3	40 – 49	Q23		Q33	Q40				
0	30 – 39								
28	No. above 70%	3	6	0	4	6	3	2	4
18	No. below 70%	4	1	3	3	3	2	2	0
46	Total questions	7	7	3	7	9	5	4	4
Metric 1 61%	Percent above 70% cut-off	43%	86%	0	57%	67%	60%	50%	100%
39%	Percent <u>below</u> 70% cut-off	57%	14%	100%	43%	33%	40%	50%	0
Metric 2	Focus Area % Favorable Group Mean	66%	80%	54%	69%	73%	72%	65%	83%

[5] Percent Favorable Responses refers to the percent of total responses to a question that were scored as either strongly agree (5) or agree (4). Thus, for Q17 (CLW focus area Structure), between 80 and 89% of respondents scored this question as a 4 or 5; whereas only 40-49% of respondents scored Q23 (CLW focus area Structure) as a 4 or 5.
The <u>percentage</u> of neutral responses (neither agree nor disagree or no response) for each question and focus area is provided in Tables 19 – 27.
The <u>range</u> of neutral responses by survey focus area as a measure of variability is provided in Table 29.

Table 17: Distribution of Percent "Favorable" Responses by Question and by Focus Area– Cut-off Score = 70%, 2005, n = 1,919

# of Survey Questions	% Favorable Responses[6]	Structure	Policy	Funding	Human Resources	System of Care	Treatment Outcomes	Training	MHSA
0	90 – 99								
0	80 – 89								
18	70 – 79	Q17, Q21	Q24, Q25 Q26, Q27 Q28, Q30		Q37	Q42 Q43 Q45	Q51 Q54	Q55	Q60 Q61 Q62
9	60 – 69	Q 18		Q32	Q34 Q35 Q38	Q41	Q50	Q56	Q59
13	50 – 59	Q19 Q22	Q29		Q36 Q39	Q44, Q46 Q47, Q48 Q49	Q52 Q53	Q58	
4	40 – 49	Q20		Q31 Q33				Q57	
2	30 – 39	Q23			Q40				
18	No. above 70%	2	6	0	1	3	2	1	3
28	No. below 70%	5	1	3	6	6	3	3	1
46	Total questions	7	7	3	7	9	5	4	4
Metric 1 39%	Percent above 70% cut-off	29%	86%	0%	14%	34%	40%	25%	75%
61%	Percent <u>below</u> 70% cut-off	71%	14%	100%	86%	66%	60%	75%	25%
Metric 2	Mean Percent Favorable by Focus Area	56%	71%	50%	60%	63%	63%	59%	75%

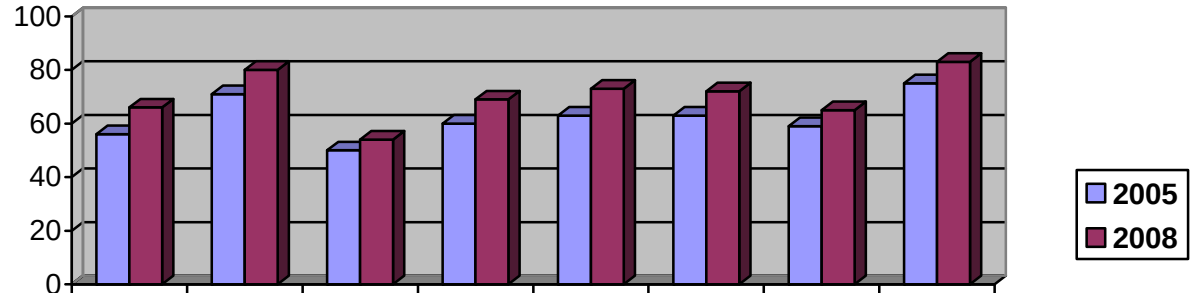
[6] Percent Favorable Responses refers to the percent of total responses to a question that were scored as either strongly agree (5) or agree (4). Thus, for Q17 (CLW focus area Structure), between 70 and 79% of respondents scored this question as a 4 or 5; whereas only 30-39% of respondents scored Q23 (CLW focus area Structure) as a 4 or 5.
The <u>percentage</u> of neutral responses (neither agree nor disagree or no response) for each question and focus area is provided in Tables 19 – 27.
The <u>range</u> of neutral responses by survey focus area as a measure of variability is provided in Table 29.

The overall pattern of the 2008 organizational cultural competency assessment survey results reflects a positive improvement from the 2005 findings. This pattern can be depicted in several ways. First, for the 2008 assessment, twenty-eight, or sixty-one (61) percent, of the questions had favorable ratings above the seventy percent cut-off score (Metric 1). Eighteen questions, thirty-nine (39) percent, had ratings below the cut-off score. This compares positively with the 2005 scores where these percentages were reversed. In 2005, 39% had favorable ratings, and 61% were unfavorable.

Second, there is a clear upward shift in the percent favorable responses across all eight focus areas. This shift is evident when comparing the percentile scores for virtually every question between 2005 and 2008. Thirty-nine questions (85%) show an upward shift in percent favorableness, whereas seven questions (15%) do not. None of the questions show a downward shift. See Table 17 (pages 15 – 16).

Third, an overall measure of improvement can be computed for each focus area by calculating the mean favorableness score for all of the questions within a focus area (Metric 2). This score provides an aggregate measure of favorableness for each focus area and enables a comparison between 2005 and 2008. These aggregate measures of focus area favorability are depicted as "Mean Percent Favorable by Focus Area" in Table 17 and Chart 1. A measurable improvement is observed in each focus area between 2005 and 2008.

Chart 1. Mean percent favorableness by focus area – 2005 and 2008.

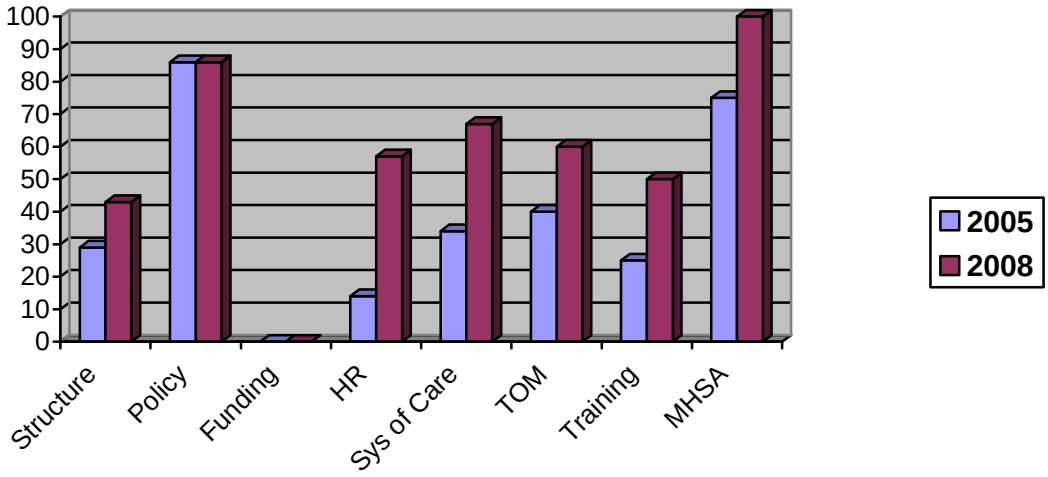


	Structure	Policy	Funding	HR	Sys of Care	TOM	Training	MHSA
2005	56	71	50	60	63	63	59	75
2008	66	80	54	69	73	72	65	83

Beyond Chart 1 as a graphic depiction of improvement across all focus areas, Chart 1 also indicates that from the point of view of an overall measurement, four of the focus areas are above the seventy percent threshold in 2008 whereas four of the focus areas are not. Policy, system of care, treatment outcome measurement, and MHSA exceed the threshold. Structure, funding, HR and training fall below the seventy percent threshold value. This reflects both achievements and areas for further assessment and improvement.

Finally, there is a significant positive improvement across six of the eight focus areas. This shift is graphically depicted in Chart 2.

Chart 2. Improvement as a function of the shift in the percentage of favorable focus area scores between 2005 and 2008.

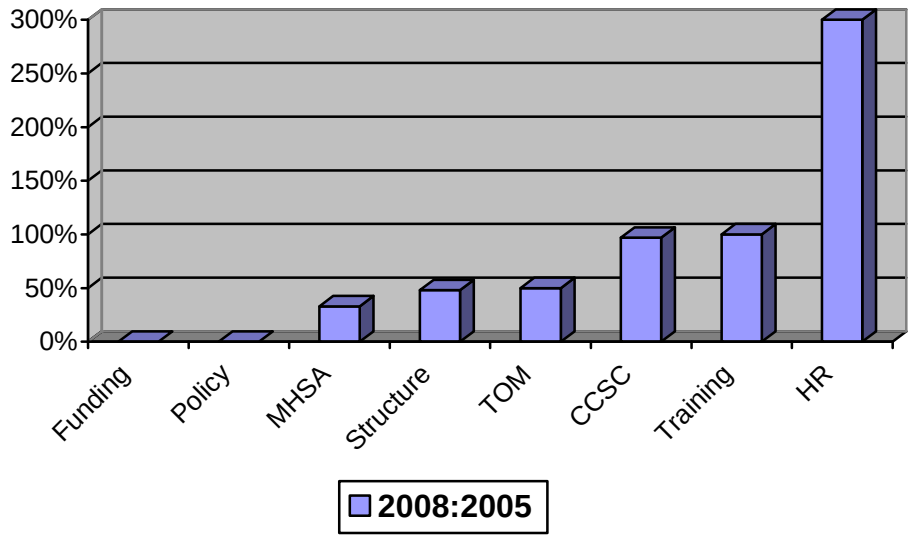


The percentage improvement in each of the eight focus areas between 2005 and 2008 is as follows:

Focus Area	Percent Improvement	Measure of Improvement
• Human Resources	300%	From 14% favorable response to 57%
• Training	100%	From 25% favorable response to 50%
• System of Care	97%	From 34% favorable response to 67%
• Treatment Outcome Measurement	50%	From 40% favorable response to 60%
• Structure	48%	From 29% favorable response to 43%
• MHSA	33%	From 75% favorable response to 100%
• Policy	0%	Held steady at 86% favorable response
• Funding	0%	Held steady at 0% favorable response

The percentage improvement across each of the eight focus areas between 2005 and 2008 is graphically depicted in Chart 3.

Chart 3. Percent improvement in favorable ratings between 2005 and 2008 across eight Focus Areas.



Findings Spotlight: Improvements

- Twenty-eight of forty-six questions (61%) had favorable ratings above the 70% cut-off score.
- There is a clear upward shift in the percent favorable responses for thirty-nine of forty-six questions (85%).
- The overall mean favorableness score across all questions within a focus area exceeded 70% for four focus areas. MHSA (83%), Policy (80%), Cultural Competency System of Care (73%), Treatment Outcome Measurement (72%).
- There is a significant positive improvement ranging from 33% to 300% in the percentage of favorable responses by question for six of eight focus areas.

The general pattern of results across the eight focus areas can be summarized in terms of level of favorability (high or low) for the number of Focus Area questions that exceeded or fell below the seventy (70%) cut-off score. Scores greater than or equal to 70% are regarded as “favorable. Scores below 70% are considered “unfavorable”. This scoring focuses attention on (a) accomplishments (favorability ratings above 70%), and (b) where to focus more attention and resources (favorability ratings below 70%). This is summarized in Table 18.

Table 18: Summary of Favorability by Focus Area, Metric 1, 2005 and 2008

	2008	2005
High Favorability (≥ 70%)	MHSA (100%)	Policy (86%)
	Policy (86%)	MHSA (75%)
Low Favorability (< 70%)	System of Care (67%)	Treatment Outcome Measurement (40%)
	Treatment Outcome Measurement (60%)	System of Care (34%)
	HR (57%)	Structure (29%)
	Training (50%)	Training (25%)
	Structure (43%)	HR (14%)
	Funding (0%)	Funding (0%)

The highest favorable ratings in both 2005 and 2008 were in "Policy" and "MHSA".

Policy. Six of seven policy related questions (86%) had favorable ratings above seventy percent for both 2005 and 2008. All seven questions benefited from an upward shift in favorability between 2005 and 2008. This pattern suggests that there are adequate policies in place to support organizational cultural and linguistic competence within the Mental Health System of Care (see Table 21).

MHSA. For 2008, all four (100%) MHSA-related questions had scores above the cut-off; each of these scored 80% or better. This is a positive shift in percent favorable responses for MHSA questions. In sum, respondents perceive their organizations as focused on the core MHSA values: (1) eliminating symptoms, (2) assisting consumers to live productive lives, (3) teaching consumers problem-solving skills, and (4) providing mental health treatment modalities that teach consumers hope.

For 2005, three of the four (75%) MHSA related questions had scores above the cut-off, and the fourth question had a favorable rating of 69% – just below the cut-off. The overall pattern of MHSA-related questions for both 2005 and 2008 suggests that the System of Care is appropriately orienting itself to the values and outcomes of the Mental Health Services Act (see Table 27). When the system makes a clear and sound commitment to a course of action, it can turn a very large ship in a new strategic direction.

The lowest favorable ratings for 2008 were in "Funding", "Structure" and "Training".

Funding (0% Favorable). All three of the funding related questions (100%) had favorable ratings below the seventy percent cut-off ranging from a low of forty-seven (47) percent (Q33) to a high of sixty-four (64) percent (Q32). This suggests that respondents don't perceive their agencies as allocating funding to support

organizational cultural competence, or are unaware of their organization's funding practices. This focus area also had some of the highest "neutral" responses (see Table 22) which may also suggest a lack of information about funding choices.

Structure (43% Favorable). Four of the seven structure-related questions (57%) had favorable ratings below the seventy percent cut off ranging from forty-six (46) percent (Q23) to sixty-six (66) percent (Q19). Respondents either did not perceive or are not aware of their agencies as engaging in the following practices:

- Consulting with community-based cultural groups about pursuing employment fairness (Q23, 46% favorable)
- Developing and reviewing programs through community consultation (Q20, 53% favorable)
- Consulting with the community to assist in service planning and delivery (Q22, 62% favorableness)
- Consulting with the staff, the community, and/or other cultural representatives to develop organizational policies and procedures (Q19, 66% favorableness).

Training (50% Favorable). Two of the four Training focus area questions (Q55, Q56) had scores above the seventy percent cut-off, and two had favorable ratings below the seventy percent cut-off. Each of the latter two (Q57, Q58) had fifty-six (56) percent favorable ratings. Respondents did not perceive their agencies as having additional support for ethno-cultural staff and volunteers (Q57), or staff time devoted to cultural competency training (Q58). See Table 26.

For the purpose of this assessment, "neutral" refers to all responses coded as "neither agree nor disagree" or for which there was no response. It is difficult to understand the meaning of no response to a particular question. At a minimum, it clearly does not mean "agree" or "disagree". As the survey was anonymous and confidential, the lack of response is assumed to be either the absence of an opinion or a lack of knowledge about a specific issue. The range of "no response" across the forty-six survey questions varies from .5% to 2.7% percent. The mean percentage of "no response" across all 46 survey questions is 1.6% or 55 respondents.

Survey results for each of the eight focus areas are summarized below (see Tables 19 – 27). For each focus area, a set of measures is displayed in each summary table. These include the mean, the standard deviation, and the percent of responses categorized as favorable, neutral, and unfavorable. Table 28 provides an overall summary of the variability of responses across the eight survey focus areas.

Structure

This category is defined by the Cultural and Linguistic Workgroup as follows:

"Structure" measures whether or not the culturally diverse stakeholders – consumers, providers and community persons – are involved in the service planning, policy making and review, and employment fairness.[7]

Seven survey questions are used to assess Structure. See questions 17 – 23, Appendix 1, or Table 19.

The emphasis in these questions is on the extent to which provider organizations, including DMH directly operated facilities as well as contractor services, utilize a broad base of community participation in the development of policies, procedures, programs, and service delivery plans.

As can be seen from Table 19, the percent favorable responses for the seven structure questions in the survey range from a low of 46% favorable (Q23) to a high of 83% (Q17). Overall, the percent of favorable responses for four of the seven structure questions fall below the seventy percent cut-off score (Q19, Q20, Q22, Q23).

The common denominator among the four questions scoring below the seventy percent cut-off score is community "consultation". Each of these four questions addresses the extent to which the community is either involved or consulted in matters of policy (Q19 – 66%) and program (Q20 – 53%) development, service planning and delivery (Q22 – 62%), and employment fairness (Q23 – 46%).

This pattern of responses suggests either of two interpretations. One, the mental health system of care lacks the necessary incentives to encourage service providers to more aggressively consult the community regarding matters of policy, program, and service delivery development.

Two, service providers do, in fact, actively solicit and encourage community consultation, but there is a breakdown in communication such that their employees do not realize it. For example, questions 20 and 23 have high response rates for the "neutral" (neither agree nor disagree) category (>30% neutral). This is suggestive of a communication breakdown.

To further test this assumption, the response patterns to these two questions are examined by position. If this is a communications breakdown, then we would expect higher favorable responses for "executives" and lower favorable responses for non-executives. Upon examination, we see that Executives do have higher favorable ratings than others – significantly so (see Table 20). However, even among executives, the favorable response rate for Q20 is only 69.9%. For Q23, the favorable response rate for executives is only 56.4%. Significant differences between executives and non-executives are observed for the other "consultation" questions as well (see Q19, Q22).

[7] Strategic Focus area definitions were developed through a series of discussions among the participants of the Cultural and Linguistic Workgroup (CLW) of the Comprehensive Community Care Implementation Committee (CCCIC), Department of Mental Health, Los Angeles County.

Table 19: All Responses by CLW Focus Area – Structure, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[8]	%Neutral[9]	%Unfavorable[10]
17. The mental health policies and procedures of my organization have been communicated to the target population or are readily available to them.	**2008**	4.2	.8	83	13	4
	2005	4.0	0.9	73	20	7
18. My organization involves various groups in decision-making such as consumers, contractors, staff, and the community.	**2008**	3.9	.9	71	20	9
	2005	3.7	1.1	60	26	14
19. The policies and procedures of my organization are developed through consultation with and input from staff, consumers, the community, and others who reflect the cultural make-up of our clients.	**2008**	3.8	1.0	66	23	11
	2005	3.5	1.1	55	29	17
20. Our programs are developed and reviewed through community consultation.	**2008**	3.6	.9	53	36	11
	2005	3.3	1.0	41	43	16
21. The staff of my organization understand and use our policies and procedures.	**2008**	4.1	.9	82	13	6
	2005	3.9	0.9	73	20	7
22. My organization has a strategy to consult with the community to assist in service planning and delivery.	**2008**	3.7	.9	62	29	9
	2005	3.5	1.0	51	37	12
23. My organization consults with various cultural groups in the community about the best ways to pursue employment fairness.	**2008**	3.5	1.0	46	41	13
	2005	3.2	1.0	37	45	19
RANGE	**2008**			46 – 83	13 – 41	4 – 13
	2005			37 – 73	14 – 39	7 – 19
DIFFERENCE	**2008**			37	28	9
	2005			36	25	8
FOCUS AREA AVERAGE	**2008**			66	25	9
	2005			56	31	13

[8] Favorable includes all responses coded as Agree or Strongly Agree.
[9] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[10] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

Table 20: Percent Favorable Response for "Less Favorable" Structure Questions: Executives and Non-Executives.

Question (Average Percent Favorable Response)	Total	Executive	Difference Executive: Total	Non-Executive	Difference Executive: Non-Executive
19. The policies and procedures of my organization are developed through consultation with and input from staff, consumers, the community, and others who reflect the cultural make-up of our clients.	66.2	85.1	18.9	67.6	17.5
20. Our programs are developed and reviewed through community consultation.	53.5	69.9	16.0	54.7	15.2
22. My organization has a strategy to consult with the community to assist in service planning and delivery.	62.9	78.5	15.6	63.7	14.8
23. My organization consults with various cultural groups in the community about the best ways to pursue employment fairness.	47.0	56.4	9.4	47.3	9.1

For each of these Focus Area – Structure questions, there is a significant difference between executive perceptions and the total sample, and between executive and non-executive perceptions.

On the bright side, questions 17, 18 and 21 show high favorable responses ranging from 71% to 83%. Question 17 suggests a strong communication policy regarding policies and procedures. Question 18 indicates a willingness to include a variety of constituencies in the decision-making process. Question 21 addresses staff understanding and application of policies and procedures. The pattern of responses for each of these questions suggests effective communication. If this is so, then the pattern of responses for the other four questions may be more a function of lack of infrastructure to support community consultation than poor communication. This could be tested through further research.

Policy

This category is defined by the Cultural and Linguistic Workgroup as follows:

> *This measures staff's knowledge of whether or not their agency has policies and procedures that ensure cultural competency; of whether or not they know that such policies and procedures have been communicated to their consumers and to the communities they serve.*

Seven survey questions are used to assess Policy. See questions 24 – 30, Appendix 1, or Table 21.

The emphasis in these questions is on the respondent's awareness of organizational policies that support the provision of culturally and linguistically competent services.

As can be seen from Table 21, the percent favorable responses for the seven policy questions in the survey range from a low of 66% favorable (Q29) to a high of 85% (Q30). Overall, the percent favorable responses for six of the seven policy questions are higher than the seventy percent cut-off score (Q24, Q25, Q26, Q27, Q28, Q30). Only one policy-related question (Q29) falls below the seventy percent cut-off. This pattern of responses exactly parallels the 2005 findings.

Q29 addresses the perceived use of a culturally appropriate complaint resolution process. 66% of the respondents have favorable responses to this question.

The research study is designed to elicit respondent perceptions. As such, it is not possible to determine from the data collected if a policy regarding culturally appropriate complaint resolution processes is actually lacking, if the majority of respondents are unaware of its existence, or if present, respondents do not perceive it as appropriately sensitive to their culture. Regardless, this result underscores the need for policy development, policy communication, or policy attunement to the specific cultural requirements within respondent organizations, or all three; in particular as they relate to culturally appropriate complaint resolution processes.

The Policy focus area has the second highest pattern of overall favorable responses among all of the focus areas assessed in this study. Six of seven, or eighty-six (86) percent, of the policy survey questions have favorable response rates in excess of seventy percent. This strongly suggests that the mental health system of care has formulated and communicated meaningful policies in the area of cultural and linguistic competence.

Table 21: All Responses by CLW Focus Area – Policy, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[11]	%Neutral[12]	%Unfavorable[13]
24. Our organizational statements and documents reflect that all services should be culturally competent.	**2008**	4.2	.8	83	13	4
	2005	4.0	.9	74	21	5
25. Language in our organizational statements and documents acknowledges the ethno-cultural diversity of our clients, the communities served, and the staff.	**2008**	4.0	.9	77	17	6
	2005	3.9	1.0	71	21	8
26. Our organizational statements and documents acknowledge the importance of providing equal services to all ethno-cultural and socioeconomic communities.	**2008**	4.2	.8	83	13	4
	2005	4.0	.9	74	21	5
27. Our policies and procedures are communicated to staff and/or discussed in training sessions.	**2008**	4.2	.9	83	12	5
	2005	4.0	.9	75	19	6
28. My organization has policies on multiculturalism, racism, harassment and discrimination that extend to consumers.	**2008**	4.2	.8	83	13	4
	2005	4.1	.9	74	21	5
29. My organization uses a culturally appropriate complaint resolution process.	**2008**	3.9	.9	66	28	6
	2005	3.7	1.0	56	37	7
30. My organization's employment policies do not discriminate based upon cultural characteristics.	**2008**	4.3	.8	85	12	3
	2005	4.2	.9	76	19	5
RANGE	**2008**			66 – 85	12 – 28	3 – 6
	2005			56 - 76	11 – 37	5 – 8
DIFFERENCE	**2008**			19	16	3
	2005			20	26	3
FOCUS AREA AVERAGE	**2008**			80	16	4
	2005			71	23	6

[11] Favorable includes all responses coded as Agree or Strongly Agree.
[12] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[13] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

Funding

This category is defined by the Cultural and Linguistic Workgroup as follows:

> *This measures the system's commitment to ensure funding to deliver culturally competent services to the diverse population, to recognize bilingual and bi-cultural staff, and to offer training in the area of cultural competency.*

Three survey questions are used to assess Funding. See questions 31 – 33, Appendix 1, or Table 22.

The emphasis in these questions is on the respondent's awareness of funding to support the provision of culturally and linguistically competent services, and the organization's ability to shift resources or to otherwise fund emergent needs.

As can be seen from Table 22, the focus area of funding has the overall least favorable responses from among all of the CLW Strategic Plan focus areas. All three, or 100%, of the funding questions have favorable response rates less than the seventy percent cut-off score. The percent favorable responses in this area range from a low of 47% (Q33) to a high of 64% (Q32). In general, respondents perceive a lack of funding – most notably in the arena of ability to respond to emergent needs.

Table 22: All Responses by CLW Focus Area – Funding, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[14]	%Neutral[15]	%Unfavorable[16]
31. My organization sets aside funds for cultural competency training.	**2008**	3.6	1.0	51	41	9
	2005	3.5	1.0	47	43	10
32. People with a cultural skill, such as a second language, are recognized or compensated if they use that skill for work that is over and above their specific job duties.	**2008**	3.8	1.1	64	24	12
	2005	3.8	1.1	64	26	10
33. My organization funds new initiatives that may better serve the culturally-specific needs of our staff and consumers.	**2008**	3.5	1.0	47	43	10
	2005	3.4	1.0	40	48	12
RANGE	**2008**			47 – 64	24 – 43	9 – 12
	2005			40 – 64	26 – 48	10 – 12
DIFFERENCE	**2008**			17	19	3
	2005			24	22	2
FOCUS AREA AVERAGE	**2008**			54	36	10
	2005			50	39	11

[14] Favorable includes all responses coded as Agree or Strongly Agree.
[15] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[16] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

Human Resources

This category is defined by the Cultural and Linguistic Workgroup as follows:

> *This measures whether or not the organization's (a) clinical and administrative staff reflect the demographics of the people served, (b) policies eliminate discriminatory barriers of accessibility to jobs, and (c) staff's performance evaluations address cultural competency.*

Seven survey questions are used to assess Human Resources. See questions 34 – 40, Appendix 1, or Table 23.

The seven questions in this area focus on employment fit (Q34, Q35), employment policies (Q37, Q38), and employment success (Q36, Q39, Q40).

As can be seen from Table 23, the percent favorable responses for the seven human resource questions range from a low of 46% favorable (Q40) to a high of 79% (Q37). Overall, the percent favorable responses for three of the seven human resource questions fall below the seventy percent cut-off (Q36, Q39, Q40). This represents a marked improvement over 2005.

Employment Fit. Both of the employment fit questions (Q34, Q35) exceed the seventy percent cut-off. The employment fit questions focus on the extent to which staff skills and demographics reflect the needs and characteristics of the service population. Q34 (staff skills) has a favorable response rate of 78%. Q35 (demographics) has a favorable response rate of 74%. Staff skills are more aligned with consumer needs than in 2005. Staff are perceived as more representative of the served population.

Employment Policy. Both of the employment policy questions (Q37, Q38) exceed the seventy percent cut-off. This is consistent with the other organizational policy-related questions from the Policy focus area (Q24 – Q30, Table 21).

Employment Success. All three employment success questions (Q36, Q39, Q40) have percent favorable responses below the seventy percent cut-off. Q36 addresses the issue of career paths for ethnically diverse employees. Q39 and Q40 deal with issues related to performance evaluation, both of which have bearing upon career success. Respondents may question the contribution of cultural competence to their career path opportunities or their performance evaluations.

The inclusion of cultural competence as a part of performance evaluations (Q40) warrants follow-up analysis. It has the lowest percent favorable responses among all HR Focus Area questions. 15% of the responses are unfavorable; 38% are neutral. There may be a lack of knowledge about the categories of performance assessment.

These findings suggest a need for a strategic plan for staff development.

Table 23: All Responses by CLW Focus Area – Human Resources, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[17]	%Neutral[18]	%Unfavorable[19]
34. The clinical and administrative skills of staff reflect the needs of the target population.	**2008**	4.0	.9	78	16	6
	2005	3.8	1.0	67	24	9
35. Employees (management, staff) reflect the demographics of the people served.	**2008**	3.9	.9	74	18	8
	2005	3.7	1.0	64	23	13
36. My organization provides appropriate career paths for ethnically diverse employees.	**2008**	3.8	1.0	63	29	8
	2005	3.6	1.0	55	34	11
37. My organization has implemented personnel policies on multiculturalism, racism, harassment and discrimination.	**2008**	4.1	.8	79	17	3
	2005	4.0	.9	73	22	5
38. My organization has an employment policy that eliminates unfair and discriminatory barriers of accessibility to jobs.	**2008**	4.1	.9	79	17	5
	2005	3.9	.9	68	25	7
39. My management demonstrates sensitivity to cultural differences when it conducts performance evaluations.	**2008**	3.8	1.0	64	30	6
	2005	3.7	1.0	55	36	9
40. My performance evaluations include a section on cultural competence.	**2008**	3.5	1.0	46	38	15
	2005	3.3	1.0	39	44	17
RANGE	**2008**			46 – 79	16 – 38	3 – 15
	2005			39 – 73	22 – 44	5 – 17
DIFFERENCE	**2008**			33	22	12
	2005			34	22	12
FOCUS AREA AVERAGE	**2008**			69	24	7
	2005			60	30	10

[17] Favorable includes all responses coded as Agree or Strongly Agree.
[18] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[19] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

Cultural Competency System of Care

This category is defined by the Cultural and Linguistic Workgroup as follows:

> *This area measures the organization's readiness in providing culturally competent services including service needs assessment, linguistic assistance, treatment modalities, physical environment, and program evaluation.*

Nine survey questions are used to assess Cultural Competency System of Care. See questions 41 – 49, Appendix 1, or Table 24.

The nine questions in this area focus on service responsiveness (Q41, Q42, Q44, Q45), fit (Q43), outreach (Q46, Q47), and needs assessment (Q48, Q49).

As can be seen from Table 24, the percent favorable responses for the nine cultural competency system of care questions in the survey range from a low of 61% favorable (Q49) to a high of 85% (Q43). Overall, the percent favorable responses for three of the nine cultural competency system of care questions fall below the seventy percent cut-off score (Q47, Q48, Q49). This is a marked improvement over the 2005 findings where only three of nine Focus Area questions fell above the cut-off score.

Service Responsiveness. All four of the service responsiveness questions have percent favorable responses above the seventy percent cut-off. Respondents perceive their organizations as eliminating barriers to service access (Q41), providing appropriate linguistic assistance (Q42), as planning, developing, and implementing culturally appropriate services (Q44), and welcoming of all clients (Q45).

Fit. The "fit" question (Q43) has a high favorable response rate (85%) and focuses on the extent to which clinic consumers are perceived as representative of the community served.

Outreach. Of the two questions on outreach (Q46, Q47), one has favorable responses at the seventy percent cut-off (Q46), the other has favorable responses below the cut-off (Q47). Promotional and educational materials are perceived as sufficiently culturally sensitive and accessible (Q46), whereas organizations are not seen as collaborating and partnering with other organizations to develop responsive services (Q47).

Needs Assessment. Finally, the two questions on needs assessment (Q48, Q49) have favorable response rates below the seventy percent cut-off. This suggests that respondents do not perceive their organizations as actively assessing the demographic characteristics of their consumer populations and identifying and addressing their cultural needs.

Table 24: All Responses by CLW Focus Area – Cultural Competency System of Care, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[20]	%Neutral[21]	%Unfavorable[22]
41. My organization takes action to eliminate barriers to service access.	**2008**	4.0	.8	74	22	4
	2005	3.8	.9	64	30	6
42. Our organization provides translators, interpreters, or multicultural staff to assist non-English speaking consumers.	**2008**	4.1	.9	81	13	6
	2005	4.1	.9	77	18	5
43. Our consumers are reflective of the community served.	**2008**	4.2	.8	85	12	2
	2005	4.1	.8	76	21	3
44. My organization plans, develops, and implements culturally appropriate service delivery models.	**2008**	3.9	.9	71	23	6
	2005	3.7	.9	59	33	8
45. My organization provides a welcoming environment for all clients.	**2008**	4.2	.8	84	12	4
	2005	4.0	.9	73	21	6
46. Our promotional and educational materials are culturally sensitive and accessible to all consumer target groups.	**2008**	3.9	.9	70	24	6
	2005	3.7	.9	58	34	8
47. My organization collaborates and partners with other organizations to develop and deliver culturally responsive services.	**2008**	3.9	.9	67	27	6
	2005	3.7	.9	53	39	8
48. My organization gathers information about the demographics of the targeted consumer group.	**2008**	3.9	.9	65	30	5
	2005	3.7	.9	54	39	7
49. Our programs are regularly assessed with respect to identifying and addressing gaps, barriers or inappropriate services in terms of cultural needs	**2008**	3.8	.9	61	31	8
	2005	3.6	1.0	51	39	10
RANGE	**2008**			61 – 85	12 – 31	2 – 6
	2005			51 – 77	18 – 39	3 – 10
DIFFERENCE	**2008**			24	19	4
	2005			26	21	7
FOCUS AREA AVERAGE	**2008**			73	22	5
	2005			63	30	7

[20] Favorable includes all responses coded as Agree or Strongly Agree.
[21] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[22] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

Treatment Outcome Measurement

This category is defined by the Cultural and Linguistic Workgroup as follows:

> *This area assesses the organization's development and implementation of reliable, valid outcome measurement in response to consumers' satisfaction with services.*

Five survey questions are used to assess Treatment Outcome Measurement. See questions 50 – 54, Appendix 1, or Table 25.

The five questions in this area focus on service review and evaluation (Q50, Q52, Q53), and service delivery (Q51, Q54).

As can be seen from Table 25, the percent favorable responses for the five treatment outcome measurement questions in the survey range from a low of 61% favorable (Q52) to a high of 80% (Q54). Overall, the percent favorable responses for two of the five treatment outcome measurement questions fall below the seventy percent cut-off score (Q52, Q53).

Service Review and Evaluation. Two service review and evaluation questions have percent favorable responses below the 70% cut-off (Q52, Q53). This suggests that respondents do not perceive their organizations as adequately evaluating culturally-specific service effectiveness, or community satisfaction with services. In contrast with 2005, respondents perceive that program practices are reviewed for consistency with policies and procedures (Q50).

Service Delivery. Both of the service delivery questions (Q51, Q54) have favorable response rates above the 70% cut-off. This suggests that respondents perceive their organization as providing culturally appropriate and quality services.

Table 25: All Responses by CLW Focus Area – Treatment Outcome Measurement, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[23]	%Neutral[24]	%Unfavorable[25]
50. Our program practices are reviewed for consistency with policies and procedures.	**2008**	4.0	.9	74	21	5
	2005	3.8	.9	62	31	7
51. My organization provides culturally appropriate services.	**2008**	4.0	.8	78	18	4
	2005	3.9	.9	70	24	6
52. My organization evaluates the effectiveness of our culturally-specific services.	**2008**	3.8	.9	61	32	7
	2005	3.6	1.0	59	30	11
53. My organization gathers feedback from the community regarding their satisfaction with our services.	**2008**	3.9	.9	66	27	6
	2005	3.6	1.0	54	36	10
54. My organization ensures that every consumer receives the best quality of care.	**2008**	4.1	.9	80	15	5
	2005	3.9	.9	70	23	7
RANGE	**2008**			61 – 80	15 – 32	4 – 7
	2005			54 – 70	23 – 36	6 – 11
DIFFERENCE	**2008**			19	17	3
	2005			16	13	5
FOCUS AREA AVERAGE	**2008**			72	23	6
	2005			63	29	8

[23] Favorable includes all responses coded as Agree or Strongly Agree.
[24] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[25] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

Training

This category is defined by the Cultural and Linguistic Workgroup as follows:

> *This area measures the organization's technical support in providing the training and assistance necessary to ensure staff's cultural competence in delivering service for the target population.*

Four survey questions are used to assess Training. See questions 55 – 58, Appendix 1, or Table 26.

The four questions in this area focus on training plans for service accessibility (Q55), and overall training and support (Q56, Q57, Q58).

As can be seen from Table 26, the percent favorable responses for the four training questions in the survey range from a low of 56% favorable (Q57, Q58) to a high of 79% (Q55). Overall, the percent favorable responses for two of the four training questions fall below the seventy percent cut-off score (Q57, Q58), and one falls right at the cut-off (Q56).

Training and Support. Two of three of the training and support questions have percent favorable responses below the 70% cut-off (Q57, Q58). Respondents do not perceive their organizations as providing additional support to bicultural staff and volunteers (Q57), or setting aside appropriate staff time for cultural competency training (Q58).

Training Plan. Seventy-nine (79) percent feel that their organizations have a training plan in place that acknowledged the importance of providing relevant and accessible services to the target population (Q55).

The lower scores in training and support suggest that respondents (1) are not sufficiently aware of training opportunities within the system of care, (2) lack the resources to participate (for example, time off, financial support, travel assistance, impact on productivity, etc), or (3) perceive themselves as having a need for training and support greater than the system's current capability.

Table 26: All Responses by CLW Focus Area – Training, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[26]	%Neutral[27]	%Unfavorable[28]
55. The training plan of my organization acknowledges the importance of providing relevant and accessible services to the target population.	**2008**	4.1	.9	79	17	5
	2005	4.0	.9	71	24	5
56. My organization provides training to all staff to increase their awareness of cultural competency.	**2008**	3.9	1.0	70	21	9
	2005	3.8	1.0	65	25	10
57. My organization provides additional support to ethno-cultural staff and volunteers where required.	**2008**	3.7	.9	56	36	8
	2005	3.5	1.0	46	42	12
58. Staff time is set aside for cultural competency training.	**2008**	3.6	1.0	56	31	14
	2005	3.6	1.0	54	31	15
RANGE	**2008**			56 – 79	17 – 36	5 – 14
	2005			46 – 71	21 – 36	5 – 15
DIFFERENCE	**2008**			23	19	9
	2005			25	15	10
FOCUS AREA AVERAGE	**2008**			65	26	9
	2005			59	31	11

[26] Favorable includes all responses coded as Agree or Strongly Agree.
[27] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[28] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

Mental Health Services Act

This category was not addressed by the Cultural and Linguistic Workgroup in their original strategic planning (circa 2000 – 2001); their planning efforts pre-dated passage of the Mental Health Services Act. Nonetheless, it was added as a response category (Focus Area) for the 2005 assessment. It is based upon key concepts promoted by the Mental Health Services Act. In particular, it seeks to assess respondent perceptions of their organization's focus on various elements of the Recovery Model. These include (1) symptom reduction or elimination, (2) productive lives, (3) problem-solving skills, and (4) hope.

Four survey questions are used to assess the system's practices of these concepts from the Mental Health Services Act. See questions 59 – 62, Appendix 1, or Table 27.

As can be seen from Table 27, the percent favorable responses for the four MHSA questions in the survey range from a low of 80% favorable (Q59) to a high of 85% (Q60). Overall, the percent favorable responses for all four MHSA questions fall <u>above</u> the seventy percent cut-off score.

Overall, respondents feel their organizations are focused on reducing or eliminating symptoms (Q59), and assisting consumers in the development of productive lives (Q60), problem-solving skills (Q61), and hope (Q62).

This is the only Focus Area where one hundred (100) percent of the questions fall above the seventy (70) percent cut-off score. This suggests that when the system makes a clear and sound commitment to a course of action and backs it up with resources, communication strategies and behavioral reinforcement, it can turn a very large ship in a new strategic direction.

Table 27: All Responses by CLW Focus Area – MHSA, n = 3,443 (2008); n = 1,919 (2005)

Questions		Mean	Std Dev	%Favorable[29]	%Neutral[30]	%Unfavorable[31]
59. In planning and delivering services, my organization focuses on reducing or eliminating symptoms.	**2008**	4.2	.8	80	18	3
	2005	4.0	.9	69	26	5
60. In planning and delivering services, my organization focuses on assisting the consumer to live a productive life.	**2008**	4.3	.8	85	13	2
	2005	4.1	.9	78	18	4
61. My organization provides mental health treatment modalities that teach consumers problem-solving skills.	**2008**	4.3	.8	84	13	3
	2005	4.1	.9	77	19	4
62. My organization provides mental health treatment modalities that teach consumers hope.	**2008**	4.2	.8	83	14	3
	2005	4.1	.9	74	22	4
RANGE	**2008**			80 – 85	13 – 18	2 – 3
	2005			69 – 78	18 – 26	4 – 5
DIFFERENCE	**2008**			5	6	1
	2005			9	8	1
FOCUS AREA AVERAGE	**2008**			83	14	3
	2005			75	21	4

[29] Favorable includes all responses coded as Agree or Strongly Agree.
[30] Neutral includes all responses coded as Neither Agree Nor Disagree or No Response.
[31] Unfavorable includes all responses coded as Disagree or Strongly Disagree.

In sum, as indicated in Table 17 (pages 15-16), twenty-eight questions (61%) across all focus areas have favorable responses that exceed the seventy percent cut-off; eighteen questions (39%) fall below the seventy percent cut-off. Thirty-nine questions (85%) demonstrated an upward shift that moved them from one percentile ranking to another (e.g., from 50 percentile to 60 percentile). Of these, the shift in ten questions moved them above the seventy percent cut-off. The remaining seven questions showed positive movement, but did not move them out of the percentile ranking they had in the 2005 survey.

The ten questions that shifted above the seventy percent cut off came from six of eight focus areas. The average increase in percent favorable responses across these ten questions was 10.5 points. Table 28 shows these ten questions, the issues they represent, the shift in the percent favorable response, and the amount of the increase for each question.

Table 28: New Questions Exceeding Seventy Percent Cut-Off Score.

Question	Issue	From 2005	To 2008	Increase
Structure				
Q18. My organization involves various groups in decision making such as consumers, contractors, staff and the community	Involving others in decision-making	60%	71%	+ 11
Human Resources				
Q34. The clinical and administrative skills of staff reflect the needs of the target population.	Staff skills reflect population need	67%	78%	+ 11
Q35. Employees (management, staff) reflect the demographics of the people served	Employees reflect client demographics	64%	74%	+ 10
Q38. My organization has an employment policy that eliminates unfair and discriminatory barriers of accessibility to jobs	Anti-discrimination policies	68%	79%	+ 11

Question	Issue	From 2005	To 2008	Increase
Cultural Competency System of Care				
Q41. My organization takes action to eliminate barriers to service access	Positive action to eliminate service barriers	64%	74%	+ 10
Q44. My organization plans, develops and implements culturally appropriate service delivery models	Use culturally appropriate service model	59%	71%	+ 12
Q46. Our promotional and educational materials are culturally sensitive and accessible to all consumer target groups	Culturally accessible materials	58%	70%	+ 12
Treatment Outcome Measurement				
Q50. Our program practices are reviewed for consistency with policies and procedures	Program, policy, and procedural consistency	62%	74%	+ 12
Training				
Q56. My organization provides training to all staff to increase their awareness of cultural competency	Cultural competency training	65%	70%	+ 5
MHSA				
Q59. In planning and delivering services, my organization focuses on reducing or eliminating symptoms	Symptom reduction, elimination	69%	80%	+ 11
	Average Point Increase			+ 10.5

Eighteen questions (39%) across all focus areas fall below the seventy percent cut-off. These questions form the foundation for follow-up research and action. The eighteen survey questions that warrant further review and action based upon the 2008 assessment are displayed by focus area in Table 29.

Table 29: Percent Favorable Response Below 70% - Questions by Focus Area.

Question by Focus Area	Favorableness
Structure	
Q23. My organization consults with various cultural groups in the community about the best ways to pursue employment fairness.	47%
Q20. Our programs are developed and reviewed through community consultation.	54%
Q22. My organization has a strategy to consult with the community to assist in service planning and delivery.	63%
Q19. The policies and procedures of my organization are developed through consultation with and input from staff, consumers, the community, and others who reflect the cultural make-up of our clients.	66%
Policy	
Q29. My organization uses a culturally appropriate complaint resolution process.	68%
Funding	
Q33. My organization funds new initiatives that may better service the culturally-specific needs of our staff and consumers.	49%
Q31. My organization sets aside funds for cultural competency training.	52%
Q32. People with a cultural skill, such as a second language, are recognized or compensated if they use that skill for work that is over and above their specific job duties.	66%
Human Resources	
Q40. My performance evaluations include a section on cultural competence.	48%
Q36. My organization provides appropriate career paths for ethnically diverse employees.	65%
Q39. My management demonstrates sensitivity to cultural differences when it conducts performance evaluations.	65%
Cultural Competency System of Care	
Q49. Our programs are regularly assessed with respect to identifying and addressing gaps, barriers or inappropriate services in terms of cultural needs.	62%
Q48. My organization gathers information about the demographics of the targeted consumer group.	66%
Q47. My organization collaborates and partners with other organizations to develop and deliver culturally responsive services.	68%

Question by Focus Area	Favorableness
Treatment Outcome Measurement	
Q52. My organization evaluates the effectiveness of our culturally-specific services.	62%
Q53. My organization gathers feedback from the community regarding their satisfaction with our services.	67%
Training	
Q57. My organization provides additional support to ethno-cultural staff and volunteers where required.	57%
Q58. Staff time is set aside for cultural competency training.	57%

A review of these eighteen questions highlights a set of developmental opportunities for the ongoing improvement of the organizational cultural competency of the overall Mental Health System of Care. The dominant themes to be addressed through follow-up inquiry and action based upon the various focus areas include the following:

Structure
- Structures of engagement for community participation (Q19, Q20, Q22, Q23)

Policy
- Culturally-specific complaint resolution processes (Q29)

Funding
- Resources to support emergent culturally-specific needs (Q33)
- Training and rewards (Q31, Q32)

Human Resources
- Criteria for employment success (Q40)
- Career paths (Q36)
- Sensitivity in evaluations (Q39)

Cultural Competency System of Care
- Needs assessment (Q49)
- Data gathering, dissemination and utilization (Q48)
- Agency partnerships and collaborations (Q47)

Treatment Outcome Measurement
- Service effectiveness (Q52)
- Customer satisfaction (Q53)

Training
- Staff training and support (Q57, Q58)

Variability

Overall, sixty-one percent (61) of all survey responses fall above the seventy percent favorable cut-off and thirty-nine (39) percent fall below. This is the exact opposite of the 2005 findings. A measure of variability in response rates for the 2008 findings is provided in Table 30. As can be seen, the overall range across the entire survey is a low favorable response rate of 46% (Structure: Q23) to a high of 85% (System of Care, Q43; MHSA: Q60).

Table 30: Measure of Variability

	Range Percent Favorable	Range Percent Neutral	Range Percent Unfavorable
Structure	46 – 83	13 – 41	4 – 13
Difference	37	28	9
Policy	66 – 85	12 – 28	3 – 6
Difference	19	16	3
Funding	47 – 64	24 – 43	9 – 12
Difference	17	19	3
Human Resources	46 – 79	16 – 38	3 – 15
Difference	33	22	12
Cult Comp Sys of Care	61 – 85	12 – 31	2 – 6
Difference	24	19	4
Treatment Outcome	61 – 80	15 – 32	4 – 7
Difference	19	17	3
Training	56 - 79	17 – 36	5 – 14
Difference	23	19	9
MHSA	80 – 85	13 – 18	2 – 3
Difference	5	5	1

The difference in the range of percent favorable responses to each of the focus areas varies from a low of 5 points (MHSA) to 37 points (Structure). The smaller the differences in the range of favorable responses for any of the eight focus areas, the more consensual (shared) agreement in perceptions. In contrast, the larger the difference, the more varied are respondents' perceptions of the issues related to each of the eight focus areas.

For example, the area of MHSA has the smallest overall difference in the range of favorable responses among the eight focus areas. The difference is 5 points (see Table 28). This suggests the highest degree of agreement (or the lowest degree of disagreement) among the 3,443 survey respondents. The 5 point difference re-

affirms the overall pattern of responses towards MHSA reflected in the surveys. Recall from Table 27 that one hundred percent of the MHSA questions have percent favorable responses greater than 70%.

Tables 19 – 27 provide measures of the percentage of neutral (neither agree nor disagree and no response) responses by question. There is also a measure of the average percentage of neutral responses for each focus area. As can be seen, there is a combined average of 23% neutral responses across all survey focus areas with a high of 36% (focus area funding) and a low of 14% (focus area MHSA).

The focus area of funding seems to be a "black box" for survey respondents. This area may show the least amount of transparency in terms of making funding and allocation issues apparent to service providers. This may account for the large percentage of neutral and blank responses (36%). See Table 22, page 28. Alternatively, it may be that service providers see funding as the purview of administrators and therefore they do not concern themselves with these issues.

The smaller percentage of neutral and blank responses related to the MHSA focus area (14%) may suggest broad familiarity with these issues on the part of respondents. See Table 27, page 38. This area may benefit from the recent state-wide emphasis on such matters. It is accompanied by a greater amount of resources and information dissemination throughout the system.

The total response rate for this survey is estimated at approximately 34% based upon an assumption of 10,000 service providers. The overall response rate may be influenced by the perceptions of those who received the surveys at various sites throughout the system. The response rates for contractors (ranging from 1 to 159) from various facilities throughout the County suggest there may have been a perception that only one response was necessary for an entire clinic or facility (see Table 3, Appendix 2). As a result, managers may not have distributed the survey to each member of their staff though that was the research intent.

Supplemental Analysis - 2008

The previous analysis provides a thorough comparison in attitudes between 2005 and 2008 across the Cultural and Linguistic Workgroup's strategic focus areas, as well as the implementation of the Mental Health Services Act. The analysis draws attention to those areas in which the Mental Health System of Care is doing well. It also identifies focus areas and issues which represent strategic opportunities for further development of the system's organizational cultural competency.

This assessment focuses on two primary measures. First, data is examined in terms of the number of questions by focus area in which respondents have a seventy percent or greater favorableness rating (Metric 1). *This rating is defined by the total number of "agree" or "strongly agree" responses to each question for each focus area*. By this measure, it is determined that twenty-eight, or sixty-one percent, of the

questions exceed the seventy percent cut-off. It is also determined by this measure that there are only two focus areas that exceed the seventy percent cut-off across all questions within the focus area – Policy (86%) and MHSA (100%). The six focus areas that do not meet the seventy percent standard include Funding (0%), Structure (43%), Training (50%), HR (57%), Treatment Outcome Measurement (60%), and Cultural Competency System of Care (67%).

Second, data is examined in terms of whether a focus area has an overall mean score greater than seventy percent (Metric 2). *This rating is determined by calculating the overall mean favorableness ("agree", "strongly agree") <u>for all of the questions</u> within each focus area*. By this measure, four of the focus areas exceed the seventy percent cut-off, and four do not. Those that exceed the cut-off include Treatment Outcome Measurement (72%), Cultural Competency System of Care (73%), Policy (80%), and MHSA (83%). Those that fall below the seventy percent cut-off include Funding (54%), Training (65%), Structure (66%), and Human Resources (69%).

Clearly, the system is perceived as doing well in (1) its efforts to define and implement policies that support the cultural competency delivery of programs and services, and (2) its efforts to implement key principles defined within MHSA. Islands of opportunity are presented within each of the six remaining focus areas.

In this section, additional analyses provide insight into the opportunities for change and improvement – notably, in the focus areas of structure, funding and training, but also with some emphasis on HR. Data is examined in relation to a variety of demographic variables to illuminate issues of concern, and to provide guidance for areas for further research and organizational development. The demographic variables include position, organization (DMH or Contractor), population served, Service Area, gender, race, age, time with current organization, and education. Each of these is taken up in turn.

<u>By Position</u>. Table 31 shows the total percent mean favorableness rating for each focus area (Metric 2). It compares this value with the mean favorableness ratings by executives, by non-executives, and by clinical staff. There are significant differences in mean favorableness ratings between executives and the total sample, between executives and non-executives, and between executives and clinical staff.

Table 31: Comparison of Mean Favorableness Ratings between Executives and Staff.

Focus Area	3443 Total	94 Executive	Exec – Total Δ	3180 Non-Exec	Exec – Non-Exec Δ	1382 Clinical	Exec-Clin Δ
Structure	66	81	15	68	13	64	17
Policy	80	92	12	82	10	81	11
Funding	54	71	17	58	13	53	18
HR	69	84	15	72	12	71	13
CCSC	73	88	15	75	13	75	13
TOM	72	85	13	73	12	73	12
Training	65	86	11	68	18	64	22
MHSA	83	91	8	85	6	89	2
Total	70	85	13	73	12	71	14

The largest observed difference across the categories of assessment is between executives and clinical staff. This is true for all categories except MHSA, where executives and clinical staff are very much in alignment. Given the overall pattern of survey results it is not surprising that the largest differences in perceived favorableness are in the areas of structure, funding and training.

The question posed by this finding is "why is there such a discrepancy between executives and others, especially clinical staff, on the core CLW focus areas?" Executives often have a different – and usually somewhat elevated – view of their organizations. This may or may not reflect the views or the reality of those working at other levels within the system. The data here suggests a significant difference in perceptions between executives and those of the rest of their organizations. Executives do not appear to be attuned to the mood or the reality of the rest of the organization, especially those on the front lines, both clinically and administratively.

By Organization. Table 32 provides a comparison between DMH employee perceptions of favorableness with those of Contractors across all eight focus areas. Across the board, Contractor perceptions of favorableness are greater than those of DMH employees. This is especially so for Policy, Human Resources, Cultural Competency System of Care, Treatment Outcome Measurement, and MHSA.

Table 32: Comparison of Mean Favorableness Ratings between DMH and Contractors.

Focus Area	Total	1767 DMH	1676 Contractor	DMH-Contractor Δ
Structure	66	64	70	-6
Policy	80	77	86	-7
Funding	54	54	55	-1
HR	69	66	75	-9
CCSC	73	70	79	-9
TOM	72	66	79	-13
Training	65	63	69	-6
MHSA	83	79	91	-12
Total	70	67	76	-8

The question posed here is "why is there such a discrepancy in perceived favorableness across each of the focus areas between Contractors and DMH staff?" Interestingly, the smallest observed differences are in the areas of structure, funding and training. It appears that regardless of organization (DMH or Contractor), respondents across the board perceive these three focus areas as wanting.

In contrast to Tables 31 and 32 where comparisons were made across all focus areas, Table 33 and those thereafter provide data by selected demographic variables for only those focus areas where the mean favorableness ratings fall below the seventy percent cut-off. The purpose is to highlight those areas that warrant further review and assessment.

By Population Served. Table 33 shows comparisons for focus areas by population served. As can be seen, structure, funding and training are issues of concern across the board, regardless of population served. Further, more areas of concern are identified for hospital-based services, jail services, and the Public Guardian.

Table 33: Comparison of Opportunity Focus Areas by Population Served.

Focus Area	3443 Total	729 Older Adult	1635 Adult	748 TAY	1946 Child	163 PG	557 Cal-Works	197 Jail	160 Hosp	574 Crisis
Struc	66	66	68	67	67	65	68	65	62	68
Fund	54	55	55	61	56	59	59	58	48	59
HR	69	68				65		65	62	
CCSC	73								66	
TOM	72					65		66	62	
Trng	65	65	67	67	66	64	66	62	61	68
Total	67					64		63	60	

Two questions are posed here: First, "why are structure, funding and training issues of concern across the board, regardless of population served?" Second, "why are human resources, cultural competency system of care, and treatment outcome measurement concerns for some populations and not for others?"

By Service Area. Table 34 shows the comparison of key opportunity areas by Service Area. Not surprisingly, funding is an identified issue of concern across all Service Areas. Structure is a concern in six Service Areas; Training is a concern in five.

Table 34: Comparison of Key Opportunity Focus Areas by Service Area.

Focus Area	3443 Total	141 SA-1	297 SA-2	425 SA-3	316 SA-4	237 SA-5	215 SA-6	256 SA-7	250 SA-8
Structure	66		65		64		68	62	62
Funding	54	65	61	63	61	57	56	59	52
Training	65		68		65			63	64
Total									59

The question posed here is "why aren't structure and training perceived as areas of concern in some Service Areas?"

By Gender. Table 35 shows the comparison of key opportunity areas by gender. Once again, the areas of concern are structure, funding and training – regardless of gender.

Table 35: Comparison of Key Opportunity Focus Areas by Gender.

	3443	2383	796	38
Focus Area	**Total**	**Female**	**Male**	**Transgender**
Structure	66	67	69	64
Funding	54	55	59	51
Training	65	66	69	65

The question posed here is "why are structure, funding and training issues of concern, regardless of gender?"

By Dominant Racial Identity. Table 36 shows the comparison of key opportunity areas by race. In addition to structure, funding and training as key opportunity areas across racial groups, Table 34 also reveals concern about human resources for Blacks, Hispanics, and American Indians-Alaska Natives, as well as Treatment Outcome Measurement for Blacks and American Indians-Alaska Natives.

Table 36: Comparison of Key Opportunity Focus Areas by Dominant Racial Identity.

	3443	419	495	930	24	1313
Focus Area	**Total**	**A/PI**	**Black**	**Hispanic**	**NA/AN**	**White**
Structure	66		64	67	56	67
Funding	54	59	54	52	54	57
HR	69		65	69	61	
TOM	72		68		64	
Training	65	67	68	63	59	68
Total			64		59	

The question posed here is "why are human resources and treatment outcome measurement issues of concern for some racial groups but not others?"

By Age. Table 37 shows the comparison of key opportunity areas by age classifications. A review of the data indicated that there are not significant differences between the favorableness ratings of several age groups so they were combined into one category representing 26 – 55 years of age. Once again, the primary areas of concern are structure, funding and training.

Table 37: Comparison of Key Opportunity Focus Areas by Age Classifications.

	3443	152	2144	486
Focus Area	**Total**	**18 – 25**	**26 – 55**	**> 55**
Structure	66	69	66	
Funding	54	52	56	63
Training	65	64	66	

The question posed here is "why are structure and training not issues of concern for those over age 55?"

By Time with Current Organization. Table 38 shows the comparison of key opportunity areas by length of time respondents have been with their current organization. Again, the three primary focus areas of concern are structure, funding and training. It is interesting to note that those who have been with their current organization for eleven or more years do not see training as an issue of concern.

Table 38: Comparison of Key Opportunity Focus Areas by Time with Current Organization.

	3443	672	1075	415	618	227	116	151
Focus Area	**Total**	**< 1 Yr**	**1-3 Yrs**	**4-5 Yrs**	**6-10 Yrs**	**11-15 Yrs**	**16-20 Yrs**	**> 20 Yrs**
Structure	66	69	65	66	66	68	68	68
Funding	54	54	53	54	59	63	58	61
Training	65	66	62	67	68			

The question posed here is "why is training not an issue of concern for those who have been with their current organizations for more than 11 years?"

By Education. Table 39 shows the key opportunity areas based on level of attained education. In addition to structure, funding, and training, human resources is also an identified area of concern for some educational levels.

Table 39: Comparison of Key Opportunity Focus Areas by Education.

	3443	61	283	1526	146	576	574	132
Focus Area	**Total**	**High School**	**Some College**	**4-Year Degree**	**Some Grad**	**Masters**	**PhD**	**MD**
Structure	66	68	69	65	67	66		
Funding	54	51	52	47	55	58	68	55
HR		66	68	66				
Training	65	64	68	62	63	66		

The questions posed here are (1) "why is structure not an area of concern for those with the most advanced degrees (PhD/PsyD, MD)?" (2) "why is HR an issue of concern for those with a 4-year degree or less?", and (3) "why is training not an issue of concern for those with PhDs/PsyDs or MDs?"

To summarize, the diagnostic questions, organized by demographics, include:

By Position:
- Why is there such a discrepancy between executives and others, especially clinical staff, across all CLW focus areas?

By Organization:
- Why is there such a discrepancy in perceived favorableness across each of the focus areas between Contractors and DMH staff?

By Population Served:
- Why are structure, funding and training issues of concern across the board, regardless of population served?
- Why are there human resource, cultural competency system of care, and treatment outcome measurement concerns for those serving some populations and not for others?

By Service Area:
- Why aren't structure and training perceived as areas of concern in some Service Areas?

By Gender:
- Why are structure, funding and training of concern regardless of gender?

By Dominant Racial Group:
- Why are human resources and treatment outcome measurement issues of concern for some racial groups but not others?

By Age:

- Why are structure and training not issues of concern for those over age 55?

By Time with Current Organization:

- Why is training not an issue of concern for those who have been with their current organizations for more than 11 years?

By Education:

- Why are structure and training not areas of concern for those with the most advanced degrees (PhD/PsyD, MD)?
- Why is HR an issue of concern for those with a 4-year degree or less?

Taken together, this supplemental analysis of key opportunity areas by selected demographic variables helps to focus attention on specific areas of concern. It proposes a set of diagnostic questions to be addressed through additional inquiry. It reinforces the conclusion that the primary opportunity arenas for action are structure, funding and training. Finally, it provides additional focus on human resources, treatment outcome measurement, and cultural competency system of care.

SUMMARY

The 2008 Organizational Cultural Competency Assessment was completed by 3,443 respondents representing a broad cross-section of the Los Angeles County Mental Health System of Care. This is estimated to be about 34% of the total number of service providers in the system. The respondents represent an incredibly diverse set of people across a broad range of demographic characteristics.

The distribution of respondents by demographic characteristics is summarized in Tables 1 through 16. Overall, the distribution of respondents as a percent of total is quite similar between 2005 and 2008 when categorized by position (Table 1), by organization (Tables 2 & 3), by population served with the exception of TAY (Table 4), by gender (Table 6), by time in US if foreign born (Table 9), by age (Table 10), by self-identified race/ethnicity (Table 13), and in languages spoken (Table 15).

Respondent demographics differed between 2005 and 2008 on several characteristics. These included the following:

- Service Area (significant decrease in respondents as a percent of total for SAs 2, 3 and 7; Table 5)
- Time in current position (significant increase in those in their position between 1-3 years and decrease in those in their positions between 4-5 years; Table 7)
- Time in current organization (significant increase in those with their current organization between 1-3 years, significant decrease in those in their current organization between 4-5 years; Table 8)

- Education (significant decrease in those with some college or with Masters degrees, significant increase in those with “four-year degree”; Table 11).

Table 17 (pages 15-16) provides a performance scorecard for assessing the organizational cultural competence of the Los Angeles County Mental Health System of Care. It provides a performance comparison at two points in time: 2005 and 2008. Overall, the performance scorecard indicates that the percent favorable responses by question exceed the seventy percent cut-off for twenty-eight of forty-six (61%) questions (Metric 1). The percent favorable responses by question for eighteen questions (39%) falls below the seventy percent cut-off score. This compares very favorably with the previous assessment and is the inverse of the 2005 results.

As with 2005, the largest percentages of favorable responses by question are in the focus areas “Policy” (86%) and “MHSA” (100%). Alternatively, the percent favorable responses by question for each of the other six assessment focus areas are less than seventy (70) percent – the selected cut-off score. These six focus areas and their percent favorable responses by question include the following:

- Cultural competency system of care (67%: 6 of 9 questions)
- Treatment outcome measurement (60%: 3 of 5 questions)
- Human Resources (57%: 4 of 7 questions)
- Training (50%: 2 of 4 questions)
- Structure (43%: 3 of 7 questions)
- Funding (0%: 0 of 3 questions)

There is a marked upward shift in respondent perceptions of the system’s performance on virtually every measure. A comparison of 2005 with 2008 results in Table 17 (pages 15 – 16) reveals a positive upward improvement in assessment of approximately ten (10) percent on almost every question. For example, a question with a 45% favorable response in 2005 would have about a 55% favorable response in 2008.

There is a measurable improvement in the average percent favorableness across thirty-nine (85%) of the questions between 2005 and 2008 (Chart 1, page 17). Based upon this as an aggregate measure (Metric 2), four of eight focus areas exceed the seventy percent cut-off (policy, system of care, treatment outcome measurement, MHSA), and four fall below it (structure, funding, HR, training).

There is a demonstrable improvement in the percentage of questions within a Focus Area that exceed the seventy percent cut-off between 2005 and 2008 for six of the eight focus areas (Chart 3, page 19). These range from a thirty-three (33) percent increase for MHSA to a three hundred (300) percent increase for human resources.

By far, the three areas of assessment that warrant further review and action are funding (0% favorable), structure (43% favorable), and training (50% favorable). This is true based upon the overall survey results, but is also clearly demonstrated when the data is sorted by position, organization (DMH, Contractor), population served, Service Area, gender, race, age, time with current organization, and education. Human resources (57% favorable) is the fourth area that warrants attention. There is also room for improvement in cultural competency system of care and treatment outcome measurement. See Tables 29 – 37.

There are a number of initiatives that help to account for observed changes in organizational cultural competency assessments between 2005 and 2008. These include (1) outreach to under-represented ethnic populations (UREP), (2) enhancing Department-level awareness of cultural competency through ongoing MHSA implementation meetings, (3) developing strategies for increasing full-service partnership (FSP) authorizations for UREP's, (4) participation in the State Cultural Competency Advisory Committee, (5) establishing specific Cultural Competency Work Plan goals, and (6) collaborating with the California Institute of Mental Health to examine the cultural relevance of three core MHSA concepts: wellness, resilience, and recovery.

As can be seen in items (1) to (3) above, the Department has made significant commitments to enhancing understanding, outreach, and service delivery for under-represented ethnic populations. This has occurred through needs assessment and planning initiatives, the formation of ethnic-specific UREP committees, weekly meetings, and the development of strategies for increasing FSP authorizations. The emphasis of UREP is to expand culturally and linguistically competent approaches to ethnic communities that have been historically marginalized by the mental health system, and to give them a voice in the stakeholder process.

Through ongoing MHSA Implementation meetings, the needs of the UREP communities are assessed, approaches for addressing these needs are identified, community-defined evidence and promising practices of engagement are shared, and system-level needs for reducing disparities are discussed.

The Planning Division actively participates in the State Cultural Competency Advisory Committee. In this way, DMH provides state-level input into the development and expansion of responsibilities in the Cultural Competency Plan.

For the past few years the Planning Division has been instrumental in the development of annual Departmental Cultural Competency Work Plan goals.

Finally, the Department consulted with representatives of various ethnic communities to review and, as necessary, rewrite the definitions of the concepts of wellness, resilience and recovery to ensure the fit for their communities.

Taken together, these initiatives help to account for some of the significant improvements observed in the assessment scores between 2005 and 2008.

RECOMMENDATIONS

The findings of this study reveal two critical outcomes. First, they demonstrate positive improvement over those of the previous assessment in 2005. This is well documented in Table 17 (pps. 15-16) and Table 28 (pps. 39-40). Second, the findings reveal ongoing areas for development of the system of care's organizational cultural competency – equally well documented in Table 29 (pps. 41-42). The challenges these findings present are twofold and can be met through a combination of inquiry and action.

Inquiry. Two questions are posed for follow-up inquiry based upon these findings.

(1) What brought about or otherwise accounts for the observed improvements?

The observed changes are partially accounted for by Departmental initiatives undertaken over the last few years. Beyond that, systems naturally change and evolve. This reflects an additional learning opportunity. Positive change can be analyzed to understand what caused it and, therefore, how to sustain it. As a consequence, management can replicate what it is doing well.

(2) Why do the differences observed persist across demographic characteristics (see Tables 31 - 39 and the diagnostic questions, pps. 51-52)?

Some issues of concern have persisted across the 2005 and 2008 survey administrations without significant observable improvements. Given that other aspects of the system are improving without an action plan for intervention, what is hindering similar improvement on these issues? Alternatively, what will be required to effectuate desired change?

Action. The 18 questions with ratings that did not achieve the 70% favorable cut-off score point to issues of concern across seven of eight focus areas (all except MHSA). See Table 29. These issues were identified as dominant themes above (see page 42). What specific actions can be recommended to improve performance?

The recommendations section takes up inquiry and action, in turn.

INQUIRY

Inquiry 1

What brought about or accounts for observed improvements?

As noted in Table 28, ten additional questions surpassed the seventy percent cut-off in the 2008 survey. Their average point increase between 2005 and 2008 (10.5 points) was greater than that of all other questions. How is this to be explained?

A partial explanation is provided in the description above of actions the Department has undertaken over the last 2 – 3 years regarding MHSA implementation, UREP, FSP authorizations, State Cultural Competency Advisory Committee participation, specific Cultural Competency Work Plan goals, and establishing the cultural relevance of the three key MHSA concepts of wellness, resilience and recovery.

For a more complete understanding of how change was brought about, it would be useful and instructive to undertake an "after-action review". Many organizations – public and private – undertake after-action reviews. The purpose is to reflect upon and learn from experience. This enables successes to be sustained and additional learning opportunities to be identified. An after-action review can be conducted through interviews, focus groups, and archival reviews, as appropriate.

To understand these improvements, two focus groups are recommended, as well as some archival review.

Focus Groups. Focus groups are addressed in terms of purpose, process and people. The purpose of the focus groups is to develop understanding about why and how these changes occurred. The process is for eight to twelve individuals per group to meet for about two hours, and to review and engage in group level discussions about the ten areas of improvement. The people would comprise two groups: (1) a group of District Chiefs or appropriate management level with direct responsibilities for field/clinical operations, and (2) a representative group of executives (managers) from contractor agencies (ACHSA) to discuss the same issues. By examining the issues and the improvements a better appreciation can be developed of what changed, how it changed, and how it can be sustained.

Specific issues to be addressed through focus groups include the following:

- Structure
  - Structures for including consumers, contractors, staff and the community in decision-making (Q18, +11%)

- Human Resources
  - Extent to which staff ethno-cultural skills reflect population need (Q34, +11%)
- Cultural Competency System of Care
  - Actions taken to eliminate barriers to service (Q41, +10%)
  - Processes to ensure culturally appropriate service models (Q44, +12%)
  - Promotional and educational materials culturally sensitive and accessible (Q46, +12%)
- MHSA
  - Focus on symptom reduction, elimination (Q59, +11%)

Archival Review. In addition to the above, several questions would be further understood through archival review of published materials developed and disseminated since the 2005 survey. Appropriate questions to be addressed through archival review include the following:

- Human Resources
  - Extent to which employees reflect demographics of clients served (Q35, +10%)
  - Policy eliminating unfair, discriminatory barriers to employment (Q38, +11%)
- Treatment Outcome Measurement
  - Practices consistent with policies and procedures (Q50, +12%)
- Training
  - Cultural competency training (Q56, +5%)

Inquiry 2

Why do differences observed across demographics persist?

Eleven diagnostic questions were posed based upon the supplemental analyses of demographic characteristics depicted in Tables 31-39. See Table 40. As is evident from Table 40, structure, funding and training continue to be critical issues. There are also important concerns across all focus areas about (1) differences in perceptions between executives in the system and all others, and (2) the more positive ratings on the part of Contractors vis-à-vis those of DMH. Other issues, more targeted in nature, are identified for policy, HR, cultural competency system of care, and treatment outcome measurement.

Focus groups and interviews are recommended to understand these issues. The purpose and process of the focus groups is similar to those identified above. The people vary depending on the nature of the issue and the demographic.

Table 40: Summary of Diagnostic Issues for Further Research and Inquiry

Demographic	Structure	Funding	Policy	HR	CCSC	TOM	Training
Position	Exec:Non-Exec	Exec:Non-Exec	Exec:Non-Exec	Exec:Non-Exec	Exec:Non-Exec	Exec:Non-Exec	Exec:Non-Exec
Organization	DMH:Contract	DMH:Contract	DMH:Contract	DMH:Contract	DMH:Contract	DMH:Contract	DMH:Contract
Population	All	All		Older Adult Pub Guardian Jail, Hospital	Hospital	Pub Guardian Jail, Hospital	All
Service Area	SA-2, SA-4, SA-6, SA-7, SA-8 Why not 1, 3, 5?	All					SA-2, SA-4, SA-7, SA-8 Why not 1, 3, 5, 6?
Gender	All	All					All
Race	Black, Hispanic, NA/AN, White	All		Black, Hispanic, NA/AN		Black, NA/AN	All
Age	18-25, 26-55 Why not >55?	All					18-25, 26-55 Why not >55?
Time w/ Org	All	All					<1 Yr, 1-3 Yrs, 4-5 Yrs, 6-10 Yrs Why not >11 Yrs?
Education	Hi School, Some College, 4-Yr Degree, Some Grad, Masters Why not PhD, MD?	All		Hi School, Some College, 4-Yr Degree Why not any post graduate?			Hi School, Some College, 4-Yr Degree, Some Grad, Masters Why not PhD, MD?

By Position.
Why is there a discrepancy between executives and others, especially clinical staff, across all CLW focus areas?

Recommend two focus groups and six interviews.

Focus Groups. The purpose of these focus groups is to develop an understanding of why the perceptions held by executives about system performance and functioning are so different from non-executives. The process is for eight to twelve individuals per group to meet for about two hours, and to review and engage in group level discussions about the observed differences between executives and non-executives. The people: one focus group with executives (both DMH and Contractor); one focus group with a cross-section of other DMH and contractor staff by level (managerial, supervisory, clinical, support staff).

Interviews. The purpose of the interviews is to develop deeper understanding of the executive perspective, and to obtain executive insight into why significant differences exist between themselves and the rest of the system. The process of each interview would be a ninety minute one-on-one interview in which observed differences are shared and executive perspective is elicited. The people would include three DMH executives and three Contractor executives.

By Organization.
Why do contractors have favorable response rates consistently higher than DMH?

Focus Groups. Recommend two focus groups – one each with senior managers from DMH and a cross-section of senior managers from Contractors. Survey results will be shared and insights will be solicited through group discussion.

By Population Served.
In addition to structure, funding and training, why are there human resource, cultural competency system of care, and treatment outcome measurement issues for those serving some populations and not for others?

Focus Groups. Recommend nine focus groups – one for representatives of each of the served populations. The questions for each focus group will vary depending on the population served. Structure, funding and training related questions would be asked of all groups. Based on Table 40, HR-related questions would be asked in addition to the groups representing older adults, the public guardian, and jail and hospital-based services. Cultural competency system of care questions would be asked of those representing hospital-based services. Finally, treatment outcome measurement questions would be asked of those representing the public guardian, and jail and hospital-based services.

By Service Area.
Why aren't structure and training perceived as areas of concern in some Service Areas while they are issues of concern in others?

No separate action necessary. Issues related to Service Area differences can be taken up and explored in other focus groups.

By Dominant Racial Identity.
Why are human resource and treatment outcome measurement issues of concern for some racial groups but not others?

Focus Groups. Recommend three focus groups: one each for Blacks, Hispanics, and American Indian/Alaska Natives.

By Age.
Why are structure and training not issues of concern for those over age 55?

No separate action necessary. Issues related to age differences can be taken up and explored in other focus groups.

By Time with Current Organization.
Why is training not an issue of concern for those who have been with their current organization for more than 11 years?

No separate action necessary. Issues related to time with current organization differences can be taken up and explored in other focus groups.

By Education.
Why are structure and training not areas of concern for those with the most advanced degrees (PhD/PsyD, MD)?
Why is HR an issue of concern for those with a 4-year degree or less?

Focus Groups. Recommend two focus groups: one for a cross-section of those with PhD/PsyD and MD degrees; one for a cross-section of those with a 4-year degree or less.

This recommended round of data collection is driven by the joint findings of the 2005 and 2008 surveys. The overall purposes are to understand

(1) why and how change occurred so that the system can learn, and change can be sustained in the future, and

(2) how the system of care can continue improving among the seven focus areas of assessment that fall below the seventy percent cut-off score.

The proposed data collection will greatly assist DMH and the system of care to ensure its continuous improvement in relation to its organizational cultural competency capability in keeping with the State mandate.

In summary, across Inquiry 1 (Why changes occurred?) and Inquiry 2 (Why differences persist?), twenty focus groups and six interviews are recommended.

ACTION

What specific actions can be recommended to improve performance?

As noted, the eighteen questions with ratings that do not achieve the seventy percent favorable cut-off score point to issues of concern across seven of the eight focus areas (all except MHSA). What specific actions can be recommended to improve performance on these issues?

Systems change and evolve (in some cases devolve) naturally over time even absent any clear, organized attempt to guide or influence them. It is clear that the Department and the System of Care have actively pursued change in relation to the execution of the Mental Health Services Act. It has identified, appropriated, and allocated resources to ensure its implementation.

When a system mobilizes itself, and makes a clear and sound commitment to a course of action and then backs it up with appropriate resources, it can bring about significant change within a reasonably short period of time. This is evident in relation to MHSA which is a relatively new initiative yet has the highest percent favorable responses across all focus areas of assessment.

The same level of concerted effort and resources is not apparent in relation to the seven focus areas defined in the Cultural and Linguistic Workgroup strategic plan. Yes, the findings reveal positive, sometimes substantive, improvements in these focus areas. However, it is difficult to identify specific, concerted focus area actions identified, agreed to, and acted upon by the Department and/or the larger Countywide System of Care. Thus, the changes observed are more artifacts of natural evolution as opposed to outcomes designed through processes of planned data-driven organizational (system) change. As a result, many issues of concern in 2005 remain issues of concern today.

The System of Care can leverage the assessment findings to pursue data-driven organizational and system change. DMH and the larger System of Care can use these findings to plan and implement change in service of driving the system to desired outcomes.

This begs the question: “In the context of the CLW strategic plan, MHSA, and the Los Angeles County Mental Health System of Care, what are the desired outcomes?” In short, where are the additional opportunities for mobilizing change to bring about a more efficient, effective, satisfying and successful system of care?

Based upon the findings, the following desired outcomes, organized by focus area as appropriate, can be suggested for consideration, debate, decision and action:

Alignment

- *Executive and staff alignment*
  The findings suggest that staff are not in alignment with executives in their assessments of the organizational cultural competency of the system. A lack of alignment leads to inefficiency and undermines morale.

Value Leadership

- *DMH as the value leader*
  The findings suggest that Contractors have more favorable attitudes about the system than DMH staff.

Structure

- *Community engagement and participation*
  The findings suggest a lack of infrastructure to more actively support community consultation in matters of (1) employment fairness (Q23), and (2) the development, planning or review of programs, services or policies and procedures (Q19, Q20, Q22).

Policy

- *Culturally-specific complaint resolution processes*
  The findings suggest a lack of culturally-specific complaint resolution processes (Q29).

Funding

- *Funding addresses culturally-specific emergent needs, cultural competency training, and rewarding on-the-job utilization of culturally and linguistically-specific skills*
  The findings suggest staff are unaware of funding initiatives or opportunities to support the provision of culturally appropriate programs or services (Q31, Q32, Q33).

Human Resources

- *Employees understand the importance of cultural competency in their performance success*
  The findings suggest staff do not see cultural competency as a measurable attribute of their performance success (Q40).
- *Racially and ethnically diverse employees envision clear career paths*
  The findings suggest ethnically diverse staff do not see clear career paths (Q36).
- *Ethnically diverse employees feel respected and valued through the performance evaluation process*
  The findings suggest staff do not feel management is sensitive to their cultural differences in the conduct of performance evaluations (Q39).

Cultural Competency System of Care

- *Programmatic cultural needs are assessed and gaps are addressed*
  The findings suggest a lack of program assessment in relation to cultural needs (Q49).
- *Demographic data is gathered and utilized to benefit programs*
  The findings suggest a lack of demographic information in relation to targeted consumer groups (Q48).
- *Agencies actively develop partnerships and collaborations*
  The findings suggest a lack of partnerships and collaboration in service of developing and delivering culturally responsive services (Q47).

Treatment Outcome Measurement

- *Culturally-specific services are evaluated for effectiveness*
  The findings suggest a lack of evaluation of culturally-specific service effectiveness (Q52).
- *Community members provide feedback on their satisfaction with services*

  The findings suggest a lack of feedback of community satisfaction with services (Q53).

Training

- *Bicultural staff and volunteers are supported*
  The findings suggest a lack of additional support for staff and volunteers with specific bicultural skills, capabilities (Q57).
- *Time is set aside for cultural competency training*
  The findings suggest time is not set aside for cultural competency training (Q58).

Recommendations

The foregoing represents a set of desired outcomes embedded within the seven focus areas of the CLW strategic plan. They represent opportunities for enhancing the overall system in terms of efficiency, effectiveness and stakeholder satisfaction. With this in mind, the following recommendations are offered:

Alignment

- *Executive and staff alignment*
  Staff may perceive executives as out of touch, and as not understanding and supporting their issues and concerns. A lack of alignment may contribute to inefficiency, ineffectiveness and a demoralized workforce.
  - ➢ Initiate and engage Executives in more active processes of dialogue and communication with non-Executives characterized by both giving and receiving information.

- Include a broader distribution of staff in problem-solving, decision-making, action planning and implementation. Constituents should vary by age, race, gender, organizational level, function, population served, Service Area, etc. Constituents should be able to see their interests and concerns in the decisions and actions of their organization.

Value Leadership

- *DMH as the value leader*
  This may point to an underlying morale issue among DMH staff. This may become evident through some of the focus groups proposed in the Inquiry section above.
  - Engage in more active and direct communications – especially about program effectiveness and success, as well as the implementation of new initiatives – so that DMH employees have a clear understanding of progress and new directions, and that they see their own contribution to system efficacy and success.

Structure

- *Community engagement and participation*
  The system of care appears to lack necessary incentives to encourage service providers to more aggressively consult the community regarding matters of policy, program and service delivery development and review.
  - Create incentives that encourage and reward the development of structures and processes for community participation.
  - Monitor, provide feedback and coaching, and reward initiatives that create and encourage processes of community engagement and participation
  - Provide mechanisms to support community involvement and participation such as:
    - addressing stigma
    - selecting convenient meeting times
    - ensuring language sensitivity to enhance consumer, family and community member participation
    - addressing transportation needs
    - providing appropriate education about the issues
    - demonstrating openness to the involvement of all interested parties.

Policy

- *Culturally-specific complaint resolution processes*
  Consumers and the community may find it difficult to complain about programs, services, personal treatment, etc. This difficulty can be rooted in a

variety of reasons, some of which may be culturally-defined, or may be defined by the immigrant experience of being the "other", an outsider, etc. The complexity of this diversity within Los Angeles County is immense. Not all cultural differences can be attended to. Nonetheless, some suggestions are:

- Develop culturally-specific complaint resolution processes based on the threshold languages. There are ethnic differences within language groupings, but threshold languages present a viable starting point.
- Utilize established County resources such as the Dispute Resolution Program. http://css.lacounty.gov/Drp/DisputeRes.html#pagetop

Funding

- *Funding addresses culturally-specific emergent needs, cultural competency training, and rewarding on-the-job utilization of cultural and linguistic skills*
  Knowledge or awareness of funding availability can influence program initiatives, professional development opportunities and employee morale.
  - Make funding decisions transparent. There are a high percentage of "neutral" responses to the three funding related questions (see Table 22). There may be a lack of information or awareness on the part of respondents to agency funding decisions.
  - Use funding to train, support and reward employees for culturally competent skills and behaviors.
  - Encourage funding for new initiatives that support and improve cultural and linguistic competence, and that enhance the system's ability to meet emergent needs.

Human Resources

- *Employees understand role of cultural competency in performance success*
- *Racially and ethnically diverse employees envision clear career paths*
- *Ethnically diverse employees feel respected and valued through the performance evaluation process*
  Human resource policies and procedures should support staff in developing and utilizing cultural and linguistic competencies.
  - Develop a Human Resources strategic plan for staff development. This plan should address the following issues:
    - Develop and implement career paths for ethnically-diverse employees.
    - Hire/train for skills that meet the cultural and linguistic needs of the target population.
    - Train managers for sensitivity to cultural differences in performance evaluation.

        - Evaluate performance in relation to cultural – not just linguistic – competency.
    - Address issues of unfair or discriminatory employment policies. This may require further investigation into respondent perceptions of unfairness and discrimination.

Cultural Competency System of Care

- *Programmatic cultural needs are assessed and gaps are addressed*
- *Demographic data is gathered and utilized to benefit programs*
- *Agencies actively develop partnerships and collaborations*
  Programs and services need to be driven by high quality and useful data and information. There is an abundance of data in the system – perhaps an overload of data – but that data may not be directly informing service development and delivery.
    - Develop and implement culturally appropriate service delivery models that bridge indigenous cultural practices and Western clinical practice.
    - Gather, share and utilize targeted consumer group demographics.
    - Create incentives that support inter-agency collaboration in developing and delivering innovative and culturally responsive services.

Treatment Outcome Measurement

- *Culturally-specific services are evaluated for effectiveness*
- *Community members provide feedback on their satisfaction with services*
  The System of Care is in a process of continual redesign and restructuring to respond to evolving consumer and community needs, as well as in response to mandates for new initiatives. This presents measurement challenges for program efficacy and outcomes.
    - Review programs on a periodic basis for consistency with policies and procedures.
    - Evaluate programs for cultural sensitivity and effectiveness in meeting the needs of culturally and linguistically specific populations.

Training

- *Bicultural staff and volunteers are supported*
- *Cultural competency training is offered and actively promoted*
  Staff feel ill-equipped to address the diversity of clients and communities they must support. The system will never have the full complement of cultural and linguistic skills necessary to support the broad and deep diversity of Los Angeles County. Nonetheless, staff in general can be supported in developing their sensitivity to and tolerance for cultural and linguistic differences. Those with established competencies can be further supported in the exercise and development of their skills.

- Increase internally and externally provided training opportunities available to staff.
- Reduce impediments to training such as transportation, fees and an emphasis on productivity that impair knowledge and skill development.
- Identify culturally-specific opportunities for supporting ethno-cultural staff and volunteers.
- Encourage staff time for cultural competency training.
- Move diversity training beyond "awareness" to purposeful and practical skill development.

NEXT STEPS

Several next steps can be suggested based upon the overall survey findings.

INQUIRY

1. Conduct a focus group and interview study for following up on and digging beneath the 2008 survey findings as outlined above. The survey findings are used to drive the next phase of research. Are the issues surfaced through the survey real, misperceptions, a function of communication problems, etc? Interviews and focus groups can be used to tease out and clarify the issues, and to identify clear arenas for action.
2. Use the interview and focus group study to probe into and develop a deeper understanding of what "neutral" responses mean. What accounts for the high percentage of neutral responses?

ACTION

1. Devise specific plans of action in relation to the recommendations identified above. Formulate a strategic action plan for developing and enhancing system-wide organizational cultural competency. Such a plan would address all CLW focus areas and MHSA as measured in this survey. The plan should include measurable goals, resources, accountability, and timelines for each of the survey areas.
2. Develop a consumer and family member survey to assess organizational cultural competence from the user's point-of-view.

CONCLUSION

The Mental Health System of Care of Los Angeles County under the auspices of the Department of Mental Health authorized this Organizational Cultural Competency Re-Assessment as a follow-up to its 2005 assessment.

As in 2005, this is not intended as an evaluative study. The purpose of the Organizational Cultural Competency Re-Assessment is to provide a follow-up assessment to the earlier survey, and to provide a longitudinal point of comparison for the overall System of Care. This investigation accomplished that purpose. It represents a snapshot in time that can be used for past and future comparisons.

Table 17 (pages 15-16) provides the best summary of the Los Angeles County Department of Mental Health System of Care's current state of organizational cultural competency. Responses to sixty-one (61) percent of the questions (n = 28) fall above the cut-off score of seventy. Responses to thirty-nine (39) percent of the questions (n = 18) fall below the cut-off. This is the inverse of the 2005 findings.

There were a significant percentage of "neutral" responses ranging from a low of twelve percent (Policy Focus Area, Q27; Culturally Competent System of Care, Q43) to a high of forty-three percent (Funding Focus Area, Q33). A follow-up investigation could explore these issues. Tables 19 – 27 provide measures of the average percent of favorable, neutral, and unfavorable responses for each focus area.

It is hoped that the information collected and the recommendations proposed will have a positive influence on the system's growth and evolution. The implementation of the proposed recommendations will help to move the system to higher levels of performance in relation to the survey focus areas.

The provision of culturally and linguistically appropriate services, structures, policies and practices represent challenging agendas. As a systems concept, organizational cultural competence is an innovative approach. The pursuit of organizational cultural competence is complicated by the complexity inherent in the scope and the scale of the Los Angeles County Mental Health System of Care and all of its varied diversity. It is hoped that the information contained within this report will provide a functional follow-up measure and useful guidance for ongoing system development.

REFERENCES

Anand, R. (2006). *Cultural Competency in Health Care: A Guide for Trainers*. Portland, OR: National Multicultural Institute.

County of Los Angeles Department of Mental Health. (2002) *Cultural and Linguistic Workgroup Strategic Plan*, Los Angeles, CA.

Cox, R. (2003). *Health Related Counseling with Families of Diverse Cultures: Family, Health and Cultural Competencies*. Greenwood Press.

Government of British Columbia, Ministry for Children & Families. *Cultural Competency Assessment Tool.* Retrieved September 6, 2001, from http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_4.htm.

Gupta, S. (2007). *A Quick Guide to Cultural Competency*. Gupta Consulting Group.

Lecca, P. (1998). *Cultural Competency in Health, Social & Human Services: Directions for the 21st Century*. Routledge.

Peterson, B. (2004). *Cultural Intelligence: A Guide to Working with People from Other Cultures*. Intercultural Press.

Rundle, A, Carvalho, M. & Robinson, M. (2002). *Cultural Competence in Health Care: A Practical Guide*. San Francisco: Jossey-Bass.

Sue, D., Carter, R. Casas, M. & Fouad, N. (1998). *Multicultural Counseling Competencies: Individual and Organizational Development*. Newbury Park: Sage.

Tseng, W. & Streltzer, J. (2008). *Cultural Competence in Health Care*. Springer.

Wolfe, T. (2003). *Cultural Competency Organizational Assessment*, County of Los Angeles Department of Mental Health Monograph, Los Angeles, CA.

U.S. Census Bureau. *State & County QuickFacts*: Los Angeles County, California. http://quickfacts.census.gov/qfd/states/06/06037.html

APPENDIX 1: Cultural Competency Organizational Assessment Survey

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

INSTRUCTIONS

Attached you will find a copy of the Los Angeles County Mental Health System of Care Cultural Competency Organizational Assessment survey. This survey is being given to all contract and directly operated mental health service providers within Los Angeles County. As such, your participation is requested in order to contribute to an accurate assessment of the Cultural Competence of the Los Angeles County mental health System of Care.

You have two options for completing and submitting this survey.

Option 1: You may complete this survey on-line by logging in to the following web-site address.

http://www.surveytracker.net/scripts/survey.dll?AHID=03F001

Once you have logged on, simply click your cursor on the best responses, choose from the selections of "drop-down" boxes, or write-in your responses, as appropriate.

Option 2: Write your responses directly onto the attached survey. For questions asking you to select a response between 1 and 5 simply place a large **X** in the box that best fits your response. For all other questions, please check the appropriate answer or write-in the best response.

After completing the survey, please fold it, place it in the attached self-addressed and postage paid envelope, and drop it in the mail.

Your responses are anonymous and completely confidential. Only statistical results will be used for reporting purposes. Individual responses will not be identified in any way.

PLEASE COMPLETE AND RETURN THIS SURVEY AS SOON AS POSSIBLE, BUT NO LATER THAN FRIDAY, NOVEMBER 7, 2008

Your participation in this assessment is sincerely appreciated, and will contribute to the understanding of the cultural competence of the mental health system of care.

Thank you!

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

REQUEST FOR PARTICIPATION AND INSTRUCTIONS

The Los Angeles County Department of Mental Health is conducting a Cultural Competency Organizational Assessment. The purpose of this assessment is to gather information that will assist the Department in understanding the level of Cultural Competency that exists throughout the countywide Mental Health System of Care. The assessment is in compliance with the State Department of Mental Health requirement for an audit of the Cultural Competency of all Mental Health contract and direct service providers.

For the purposes of this assessment, "cultural competency" refers to organizational structure and practices that contribute to the effective delivery of culturally and linguistically appropriate services where differences are acknowledged, valued, respected, and embraced.

This survey has been endorsed by Dr. Southard, Director, Department of Mental Health, Los Angeles County. The Association of Human Community Service Agencies (ACHSA) Board of Directors supports this Cultural Competency Survey.

This survey is being given to all employees of all contract and directly operated mental health service providers within Los Angeles County. As such, your participation is requested in order to contribute to an accurate assessment of the Cultural Competence of the Los Angeles County mental health System of Care.

Your responses will be confidential and anonymous. Your name or personal identifying information is NOT required. All responses will be collected by an independent third party. Information will be used for statistical and comparative purposes only.

Please respond to the following questions as honestly and as accurately as possible. Answer each question in terms of your knowledge and understanding of the specific organization that you work for. For example, when answering question #1, choose your answer based upon your belief about the extent to which the policies and procedures of your agency, program, clinic, etc have been communicated to the target population or are readily available to them.

There are no "right" or "wrong" answers. We are interested in your opinion.
The entire questionnaire should take you about 15 minutes to complete.

If you are completing a hard copy questionnaire, upon completion, please insert it in the attached addressed and postage paid envelope, and drop it in a convenient mailbox.

If you have any questions or concerns, or would like additional information about the Cultural Competency Organizational Assessment, please feel free to contact either individual listed below:

Terry Wolfe, PhD at (323) 258-4675 or email at terry.wolfe@ae2gis.com
Tara Yaralian, PsyD at (213) 251-6814 or email at tyaralian@dmh.lacounty.gov

Your responses are very important to the effective assessment of cultural competency within the Los Angeles County Mental Health System of Care. We very much value your participation.

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

Your opinions are requested to assist in the assessment of cultural competence in the Los Angeles County Mental Health System of Care. This survey is being distributed to LA County DMH directly operated and contract service providers. There are no "right" or "wrong" answers. Rather, we are interested in your opinion. Your responses are confidential. Statistical data and profiles that summarize all of the responses will be developed. Demographic information is requested to facilitate comparisons between different groups. Findings and recommendations will be available to all entities that participate in the assessment.

Please read each question carefully, and indicate your answers by filling in the responses.

If you have any questions, please contact:
Terry Wolfe, PhD at (323) 258-4675 or email at terry.wolfe@ae2gis.com
Tara Yaralian, PsyD at (213) 251-6814 or email at tyaralian@dmh.lacounty.gov

This survey will take about 15 minutes to complete

Current Position: Level
___ Executive
___ Managerial
___ Supervisory
___ Clinical
___ Support Staff
___ Other _____
(please specify)

Current Organization
DMH Directly Operated
___ Program Name _____
___ Hospital Name _____
___ Clinic Name _____
Contractor
___ Hospital Name _____
___ Clinic Name _____
Other: _____
(please specify)

Populations Served
___ Older Adult
___ Adult
___ TAY
___ Children
___ Public Guardian
___ Cal-Works/GROW
___ Jail Services
___ Hospital-based
___ Crisis
___ Other (please specify) _____

Service Area: ___

Your Gender
___ Female
___ Male

Length of time in <u>current position</u>	__ < 1 yr	__ 1-3	__ 3-5	__ 5-10	__ 10-15	__ 15-20	__ > 20
Length of time with <u>organization</u>	__ < 1 yr	__ 1-3	__ 3-5	__ 5-10	__ 10-15	__ 15-20	__ > 20
If foreign born, length of time in US	__ < 1 yr	__ 1-3	__ 3-5	__ 5-10	__ 10-15	__ 15-20	__ > 20
Your age	__ 18-25	__26-35	__36-45	__ 46-55	__ 56-65	__ over 65	

Highest level of Education **(check one)**
___ High School
___ Some College
___ 4 Year Degree (major): _____
___ Graduate School (field): _____
___ Master's Degree (field): _____
___ PhD (field): _____
___ MD (field): _____
___ Other: _____
(please specify)

For purposes of statistics, please specify your dominant racial/cultural/ethnic identity:

__ Asian/Pacific Islander __ Black __ Hispanic __ Native American / Alaska Native __ White

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

Racial and Cultural/Ethnic Identity (Choose all that apply)

__ White
__ Black
__ Hispanic
__ American Indian/ Alaska Native
__ Chinese
__ Japanese
___ Filipino
___ Other Asian/Pacific
___ Other Non-White
___ Korean
___ Indochinese
___ Amerasian
___ Cambodian
___ Samoan
___ Asian Indian
___ Hawaiian Native
___ Guamanian
___ Laotian
___ Vietnamese
___ Other Black _____
___ Other White _____
___ Other Hispanic _____
___ Other Native American _____
___ Other _____
___ Unknown/Not Reported

What languages do you speak other than English? (check all that apply)

___ Arabic
___ Armenian
___ Cambodian
___ Cantonese
___ Chinese
___ Farsi
___ Korean
___ Mandarin
___ Russian
___ Spanish
___ Tagalog
___ Vietnamese
___ Other – please specify _____
_____
_____

Name your country of origin _____

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

RATING Item	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
Structure					
17. The mental health policies and procedures of my organization have been communicated to the target population(s) or are readily available to them.	1	2	3	4	5
18. My organization involves various groups in decision-making such as consumers, contractors, staff, and the community.	1	2	3	4	5
19. The policies and procedures of my organization are developed through consultation with and input from staff, consumers, the community, and others who reflect the cultural make-up of our clients.	1	2	3	4	5
20. Our programs are developed and reviewed through community consultation.	1	2	3	4	5
21. The staff of my organization understand and use our policies and procedures.	1	2	3	4	5
22. My organization has a strategy to consult with the community to assist in service planning and delivery.	1	2	3	4	5
23. My organization consults with various cultural groups in the community about the best ways to pursue employment fairness.	1	2	3	4	5
Policy					
24. Our organizational statements and documents reflect that all services should be culturally competent.	1	2	3	4	5
25. Language in our organizational statements and documents acknowledges the ethno-cultural diversity of our clients, the communities served, and the staff.	1	2	3	4	5
26. Our organizational statements and documents acknowledge the importance of providing equal services to all ethno-cultural and socioeconomic communities.	1	2	3	4	5

RATING Item	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
27. Our policies and procedures are communicated to staff and/or discussed in training sessions.	1	2	3	4	5
28. My organization has policies on multiculturalism, racism, harassment and discrimination that extend to consumers.	1	2	3	4	5
29. My organization uses a culturally appropriate complaint resolution process.	1	2	3	4	5
30. My organization's employment policies do not discriminate based upon cultural characteristics.	1	2	3	4	5

Funding

31. My organization sets aside funds for cultural competency training.	1	2	3	4	5
32. People with a cultural skill, such as a second language, are recognized or compensated if they use that skill for work that is over and above their specific job duties.	1	2	3	4	5
33. My organization funds new initiatives that may better serve the culturally-specific needs of our staff and consumers.	1	2	3	4	5

Human Resources

34. The clinical and administrative skills of staff reflect the needs of the target population.	1	2	3	4	5
35. Employees (management, staff) reflect the demographics of the people served.	1	2	3	4	5
36. My organization provides appropriate career paths for ethnically diverse employees.	1	2	3	4	5
37. My organization has implemented personnel policies on multiculturalism, racism, harassment and discrimination.	1	2	3	4	5

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

RATING Item	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
38. My organization has an employment policy that eliminates unfair and discriminatory barriers of accessibility to jobs.	1	2	3	4	5
39. My management demonstrates sensitivity to cultural differences when it conducts performance evaluations.	1	2	3	4	5
40. My performance evaluations include a section on cultural competence.	1	2	3	4	5

Cultural Competency System of Care

41. My organization takes action to eliminate barriers to service access.	1	2	3	4	5
42. Our organization provides translators, interpreters, or multicultural staff to assist non-English speaking consumers.	1	2	3	4	5
43. Our consumers are reflective of the community served.	1	2	3	4	5
44. My organization plans, develops, and implements culturally appropriate service delivery models.	1	2	3	4	5
45. My organization provides a welcoming environment for all clients.	1	2	3	4	5
46. Our promotional and educational materials are culturally sensitive and accessible to all consumer target groups.	1	2	3	4	5
47. My organization collaborates and partners with other organizations to develop and deliver culturally responsive services.	1	2	3	4	5
48. My organization gathers information about the demographics of the targeted consumer group.	1	2	3	4	5
49. Our programs are regularly assessed with respect to identifying and addressing gaps, barriers or inappropriate services in terms of cultural needs.	1	2	3	4	5

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

RATING Item	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
Treatment Outcome Measurement					
50. Our program practices are reviewed for consistency with policies and procedures.	1	2	3	4	5
51. My organization provides culturally appropriate services.	1	2	3	4	5
52. My organization evaluates the effectiveness of our culturally-specific services.	1	2	3	4	5
53. My organization gathers feedback from the community regarding their satisfaction with our services.	1	2	3	4	5
54. My organization ensures that every consumer receives the best quality of care.	1	2	3	4	5
Training					
55. The training plan of my organization acknowledges the importance of providing relevant and accessible services to the target population.	1	2	3	4	5
56. My organization provides training to all staff to increase their awareness of cultural competency.	1	2	3	4	5
57. My organization provides additional support to ethno-cultural staff and volunteers, where required.	1	2	3	4	5
58. Staff time is set aside for cultural competency training.	1	2	3	4	5
MHSA					
59. In planning and delivering services, my organization focuses on reducing or eliminating symptoms.	1	2	3	4	5
60. In planning and delivering services, my organization focuses on assisting the consumer to live a productive life.	1	2	3	4	5

Los Angeles County – Department of Mental Health
Program Support Bureau
Cultural Competency Organizational Assessment
Los Angeles County Mental Health System of Care

RATING Item	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
61. My organization provides mental health treatment modalities that teach consumers problem-solving skills.	1	2	3	4	5
62. My organization provides mental health treatment modalities that teach consumers hope.	1	2	3	4	5

63. Please provide any additional comments that you believe will assist in understanding the cultural competency of your organization.

APPENDIX 2: Contractor Agencies Identified in Survey Responses

RESPONDENT CONTRACTOR AGENCIES (n = 254)

1736 Family Crisis Center	Bellflower Medical Center
66th Hurlbut, Wellness Center	Bienvenidos
8300 S. Vermont	BRIDGES
97th St	C&FC
AADAP Clinic	California Hispanic Commission
ABI/ABLE Harbor UCLA	California Hospital-California Behavioral Health Center
ACCESS	CalWORKs
Alafia Mental Health	CBSC
Alcott Center	CCAV
Alfa family services	CCC
ALMA	CDFC
Almansor	Cedars Sinai
Aluiansa Center	Center for Aging Resources/Heritage Clinic
Amanecer Community Counseling Service	Center for Family Living
Ambulance	CFAR
AMHF	CHCADA
Antelope Valley Hospital	Child & Family Center
API Mental Health Alliance	Child and Family Development Center
Arcadia MHC	Child and Family Guidance Center
Asian American Drug Abuse Program	Child, Youth and Family Program Administration
Asian Pacific Counseling and Treatment Centers	ChildNet Youth and Family Services
Asian Pacific Family Center	Children's Center
Augustus Hawkins	Children's Hospital Los Angeles
Aurora Las Encinas Hospital	Children's Institute, Inc.
Aviva Family and Children's Services	Choices
Azusa Pacific University	CHW
Behavioral Health Services, Inc.	CIFHS

RESPONDENT CONTRACTOR AGENCIES
(continued)

CII	Dubnoff
CIMH	East Valley Hospital Mental Health
City of Angels	Eastlake Youth Ctr.
CKLMC	Edelman
CMHC	Eisner Pediatric and Family Medical Center
Community Agency	El Cento de Amistad
Community Care Center	El Centro del Pueblo
Community Care Inc	El Monte ACT
Community Family Guidance Center	EMQ Hollygrove
Compton Mental Health	EPFMC
Compton System of Care	Excelsior Youth Center
Contract Agency	Exceptional Children's Foundation - Kayne Eras Center
Cornerstone	Exodus Recovery
Counseling 4 Kids	F.A.S.G.I
Crittenton	Family Crisis
CSCF	Family Preservation
CSMC Hospital	Family Stress Center
CSS	Female Residential Tx. Facility
CVYFC	FFS
David & Margaret	Five Acres
Devereux	Foothill Family Service
Didi Hirsch	For The Child
Dorothy Kirby Center	Gateways
Downtown Mental Health Center	Glen Roberts Child Study Center Verdugo Mental Health
Drew Child Development	Group Home
Drug and Alcohol TX Center	Harbor UCLA
Dual Diagnosis Rehab Residential	Hathaway Sycamores Child & Family Services

RESPONDENT CONTRACTOR AGENCIES
(continued)

Health Research Association	Long Beach Mental Health
Heritage Clinic	Los Angeles Child Guidance Clinic
Hillsides	M4A Village
Hillview Mental Health Center	Maryvale
HMH	Masada Homes
Hollygrove/EMQ	McDonald Carey MHC
Hollywood Mental Health Center	McKinley Children's Center
Homeless Shelter	Mental Health Advocacy Services
Homes for Life Foundation	Mental Health Agency
HOPE	Mental Health America
Hospital	MTFC
HUD	New Directions
Huntington	New Horizons
IMCES	New Horizons Family Center
IMD-Community Care Center	Non-Profit
Independent Living	North Valley Youth & Family Center
Intensive Day Treatment Programs	Northpoint
Intercommunity Child Guidance Center	Northridge Hospital
Intermountain	Occupational Therapy Training Program
Jewish Family Services	Olive Crest
Koreatown Youth & Community Center	One in Long Beach
L.A. Family Housing	OPCC
LAGLC	Optimist
Landmark Medical	OVMC
Las Encinas Hospital	OYHFS
LAUSD	Pacific Asian Counseling Services
LB API FMHC	Pacific Cedar Boys Home
Learning Skills School	Pacific Clinics

RESPONDENT CONTRACTOR AGENCIES
(continued)

Pacific Lodge	San Gabriel Children's Center
PACS	San Pedro Mental Health Center
Para Los Ninos	School
Pasadena Unified School District Mental Health Services	School Based CCAV
PC	School District
PCS	School Mental Health
Penny Lane	Self-Employed Consultant
Personal Involvement Center	Serenity Infant Care Homes, Inc.
Phoenix House LA, Inc.	SHARE
Plaza Community Services	SHELTER
PLN	Shields for Families
Portals	Skid Row Development Corporation
Primary Counselor	SMLF - Valley Clinic
Private Pay	SNF/IMD
Project Return	Social Model Recovery Systems, Inc.
Prototypes	Sorvia Shankman Orthogenic School
Providence Community Services	South Bay Mental Health Center
Residential Treatment Center	South Bay Ties for Adoption
Rio Hondo	South Central Health and Rehabilitation Program (SCHARP)
River Community	Special Services for Groups
RMD	Spirit Family Services
Rosemary Children's Services	SPMHC
RSI Ambulance	SRDC
Salvation Army Bell Shelter	SRO Housing
Salvation Army Transitional Living Center	St Anne's
San Fernando Valley Community Mental Health Center, Inc.	St John's Child and Family Development Center

RESPONDENT CONTRACTOR AGENCIES
(continued)

St John's Hospital	TTCF
St Joseph Center	TYFS
St Mary's	Valley Clinics
Star View	Verdugo Mental Health
Step Up On Second	Victory Wellness Center
Stirling Behavioral Health Institute	Village Family Services
STRIVE	Village ISA
Sub Contractor	VIP Community Mental Health Center, Inc.
Substance Abuse Foundation	Vista Del Mar
Tarzana Treatment Centers	VMH
The Children's Center	VMH Care
The Guidance Center	Well
The Help Group	West Central Mental Health
The Learning Clinic	West Valley Mental Health Center
The Long Beach Guidance Center	Westside Center of Independent Living (WCIL)
Transitional Housing	White Memorial
Travelers Aid Society of LA	Wise & Healthy Aging
TRCCF	Wraparound
Trinity El Monte	Youth Center

APPENDIX 3: Racial/Ethnic Identities

RESPONDENT RACIAL/ETHNIC IDENTITIES (n = 95)

African	Coptic
African American-Indian	Creole
African Descent- Born in the United States	Cuban
African, Sierra Leonian, Nigeria	Dutch
African-American	Ecuadorian
American	Egyptian
American-Mexican	Euro-American: Scotch/Irish/English & German (Bavaria)
Anglo Saxon	European
Anglo-American	French
Arab	French-Canadian
Argentinian	German
Armenian	German / Caucasian
Armenian, Arabic	German, English, Irish
Ashkenazy Jewish	German/Jewish
Asian American	German/Russian
Asian/Iranian/white	German/Swedish/British
Belizean	Guatemalan
Brazilian	Haitian American
British	Hetican
Bulgarian	Honduran
Burmese	Indo-European
Caribbean	Iranian
Chaldean	Irish
Cherokee	Irish American
Cherokee/Apache	Italian
Chicana/Mexican-American/Mexican	Italian American
Chicana/o	Italian, Aruban
Columbian	Italian, Irish, French, Spanish

RESPONDENT RACIAL/ETHNIC IDENTITIES
(continued)

Italian/German	Other - Unnamed
Italian/Polish	Pakistani
Italian/Portuguese	Palestinian & Russian / Jewish
Jamaican	Persian
Jewish	Persian, Armenian
Latin	Polish-American
Latina/o	Puerto Rican
Latino (Not Hispanic)	Russian
Latino, Salvadorian	Russian-American
Lebanese Armenian	Salvadorian
LGBT	Singaporean
Mexican	Slavic
Mexican / Latin American	Southeast Asian
Mexican American	Spanish
Middle Eastern	Spanish but non-Hispanic, Malayan
Mixed Asian/Latina	Sri Lankan
mixed race	Swedish
multiracial	Taiwanese
Native Jamaican	Thai
Northern European American	

APPENDIX 4: Countries of Origin

RESPONDENT COUNTRY OF ORIGIN (n = 92)

Afghanistan	Fiji	Palestine
Africa	France	Panama
Argentina	Georgia Republic	Peru
Armenia	Germany	Philippines
Australia	Ghana	Poland
Azerbaijan	Guatemala	Puerto Rico
Bangladesh	Guyana	Romania
Belarus	Haiti	
Belgium	Honduras	Russia
Belize	Hong Kong	Samoa
Bolivia	Hungary	Scotland
Bosnia – Herzegovina	India	Serbia
Brazil	Indonesia	Sierra Leone
Bulgaria	Iran	Singapore
Burma	Iraq	Slovenia
Cambodia	Ireland	South Africa
Cameroon	Israel	Spain
Canada	Italy	Sri Lanka
Chile	Jamaica	Sweden
China	Japan	Switzerland
Colombia	Kenya	Syria
Costa Rica	Korea	Taiwan
Cuba	Lebanon	Thailand
Czech Republic	Liberia	Uganda
Dominican Republic	Malaysia	Ukraine
Ecuador	Mexico	United Kingdom
EEUU	Netherlands	US
Egypt	Nicaragua	USSR
El Salvador	Nigeria	Venezuela
England	Norway	Vietnam
Ethiopia	Pakistan	Yugoslavia